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Y CHOONCEIL SLATTYSSAGH

PROCEEDINGS

DAALTYN

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Douglas, Tuesday, 12th June 2018

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Present:

The President of Tynwald (Hon. S C Rodan)

The Lord Bishop of Sodor and Man (The Rt Rev. P A Eagles),
The Attorney General (Mr J L M Quinn QC),
Miss T M August-Hanson, Mr D C Cretney, Mr T M Crookall, Mr R W Henderson,
Mrs M M Hendy, Mrs K A Lord-Brennan, Mrs J P Poole-Wilson and Mrs K Sharpe
with Mr J D C King, Clerk of the Council.

Business transacted

Legislative Council

The Council met at 10.30 a.m.

[MR PRESIDENT *in the Chair*]

The President: Moghrey mie, good morning, Hon. Members.

Members: Moghrey mie, Mr President.

The President: The Lord Bishop will lead us in prayer.

PRAYERS
The Lord Bishop

Order of the Day

1. Abortion Reform Bill 2018 –
Second Reading commenced

Mr Henderson to move:

That the Abortion Reform Bill 2018 be read a second time.

The President: Hon. Members, we turn to the single Item of business which is the Second Reading and clauses stage of the Abortion Reform Bill 2018. To move the Second Reading, I call on the Hon. Member of Council, Mr Henderson.

Mr Henderson: Gura mie eu, Eaghtyrane.

Before I start I was just wondering if I can divest myself of my jacket, sir? It is quite warm in here this morning.

The President: You may, sir.

Mr Henderson: Thank you.

Eaghtyrane, Hon. Members, at the First Reading stage of the Bill I gave a very detailed account of what it entailed and much background information at length – something I do not wish to repeat today. I would rather just give a shorter summary and appraisal of the Bill itself. In doing so, I would just like to re-emphasise a couple of the points I made at the First Reading stage, which are that this Bill has benefited from an exhaustive consultation process, one of which I think I have not seen in my service in Tynwald and certainly I think this is the Bill that has received the most consultation I

have ever come across. Further to that, it has received the resounding endorsement of the House of Keys in completing its passage through that Branch.

Eaghtyrane, the Bill comprises four Parts: Part 1 comprises clauses 1 and 3 dealing with introductory matters including the short title.

Part 2 comprises clauses 4 through to 17 dealing with and in overview, the provision of abortion services and to whom this applies; where those provisions are to be provided; who provides the services; conscientious objections and related matters; informed consent; position of Health Care professionals; provision of medical products for abortion services; imposition of duties once a termination has taken place; applies that a termination cannot take place solely on the grounds of gender, with certain exceptions; creates a new criminal offence; requires that the DHSC introduces certain counselling services; imposes a duty on the DHSC to introduce associated Regulations.

Part 3 comprises clauses 18 to 27, which deal with the creation of, or application for, access zones around premises such as hospitals and surgeries where terminations take place, or where counselling under the Bill is provided, and around the homes of those who provide or participate in the provision of abortion services.

Part 4 comprises clauses 28 and 29 authorising the Department to incur expenditure because of the resulting Act and Provisions for associated repeals.

I would just like to also add, Eaghtyrane, as I indicated at First Reading, that I would like to take clause 3 later on in the Bill following clause 27, as it forms part of the definitions and there may well be consequential effects as we progress through the clauses to that, so it would make sense to leave that until almost last.

And with that, Eaghtyrane, I beg to move the Second Reading of the Abortion Reform Bill.

The President: Hon. Member, Mrs Poole-Wilson.

Mrs Poole-Wilson: Thank you, Mr President.

In seconding the Second Reading today, I would like to reiterate my support for the proposed reform and the approach the Bill takes to enacting that reform. I would also like to reflect on what the Lord Bishop raised at the First Reading, namely the question of whether in our debate so far sufficient weight has been given to the question of the foundational right to life, the life of the unborn foetus. And I think it is an important and extremely difficult area and one that Members of this Council as well as Members of the Keys have received a lot of information about and I believe have really taken the time to think about.

One aspect of what makes this difficult is the question of when life begins. A purist approach that life begins at conception would arguably lead to questions about whether as a society we should enable access to the morning-after pill. But for the most part in society provision of the morning-after pill is accepted as part of healthcare. And based on the extensive public consultation that the Hon. Member of Council, Mr Henderson has already referred to, and the comments so far in the Keys, the principle of access to abortion services as part of healthcare has also been very widely accepted. But the questions around the extent of that access received a lot of focus and were the ones the Keys wrestled with at great length. In their extensive debates there was unanimous acceptance of the principle of reform. There was then a lot of detailed debate around the parameters for access to abortion services, precisely because it is recognised that as the pregnancy progresses things do change – the foetus develops and we know that babies have survived very premature birth.

So as Dr Allinson has pointed out, this Bill does not follow the Canadian model of what he described as a *carte blanche* approach. Rather, this Bill acknowledges that there is a continuum and the framework we put in place around accessing abortion services differs as we move along that continuum. So we move from a position which was universally accepted in the Keys, that during the first trimester abortion services should be able to be accessed on demand. In the middle trimester, access depends upon whether the registered medical practitioner is of the opinion formed in good faith that one or more of the relevant subsections apply. And in the final trimester, for the very few

women who may find that they are in the desperately difficult situation of possibly facing a late termination, there is scope still for abortion services to be provided but in very much more limited circumstances – circumstances involving risk either to the life of the mother or the foetus; or risk of grave, long-term injury to the mother's health; or the risk of the child suffering a serious impairment, a condition that has now been carefully defined through debate in the House of Keys.

In the overall approach of the Bill and in the thoughtful approach individuals have taken in debating and amending this Bill, I believe Members of the Keys and now Members of this Council are mindful of the unborn foetus. However, they are also mindful of the reality that for some women, they may face the most difficult situation of a possible abortion at some point after the first trimester; and that it is preferable that our law enables such women to be able to access the healthcare they need at that point. And while the Bill provides that access to abortion services *is* restricted to particular circumstances after the first trimester, it is surely better still to support women at any stage to receive impartial advice and information to enable them to reach a decision – a decision that in some cases may be *not* to terminate the pregnancy. It is also important, I feel, that women in that difficult position of needing to access abortion services are able to do so here, irrespective of financial means and without fear.

Thank you, Mr President.

The President: Now, the Bill having had its Second Reading moved and seconded, we are open for discussion.

Mrs Sharpe.

Mrs Sharpe: Thank you, Mr President.

I would like to take this opportunity of setting this Bill in recent historical context. Firstly, I would like to thank Mr Henderson for his unremitting hard work prior to presenting the Bill to this Hon. Chamber. I would like to thank Members of the House of Keys for their relentlessly thorough debates regarding the Bill and for their mature and reasoned discussions, and for their willingness to compromise, at times, on such an emotive subject. Thanks must also go to Mr Howard Connell for interpreting the wishes of the Keys and for drafting an elegant Bill, which is at once clear and concise. Above all, I would like to thank Dr Allinson who, through his work as a general practitioner, recognised the need for change to the Island's abortion laws and who took it upon himself to see that change through. The public have also played a significant role in the formation of the Bill which we see in front of us today. The level of open debate which we as an island nation have engaged in has been of the utmost importance to me.

To set this Bill in context, 10 years ago on behalf of the BBC, I interviewed members of the Manx public on the subject of abortion. I found a climate of fear and shame. Interviewees did not want to reveal their identities for fear of losing their jobs. No representative of the Isle of Man Government would give an interview, the Department of Health and Social Services merely stating that it was not appropriate for the Department to comment on the Island's abortion laws. I talked to GPs who were uncertain whether they were breaking the law by referring a woman to have an abortion in the UK, and to women who were still scarred from their experiences of having to access abortions across the water.

I would like to read, if I may, one interview from 2007 because I believe it encapsulates what girls and women in the Isle of Man have been subjected to for decades. And let us not forget, until this Bill becomes law, this is still the reality for girls and women in the Isle of Man. This contains one instance of swearing.

Manx-born CJ had just started her A-levels when she got pregnant. After careful consideration, she decided that she wanted an abortion. She told me:

> I'd left school at 16 and had been working in a factory since then but had started at the College doing my A-levels. It was the first time in my life that I thought there was a future for me not working in factories. Suddenly opportunities were opening up for me.

I was quite an immature 19-year-old girl. I knew I couldn't look after a baby. People on the Isle of Man are quite conservative and it would have been very difficult for a 19-year-old girl on her own.
When I'd decided that I was just not ready to have a baby I confided in my sister. We knew I couldn't get an abortion on the Isle of Man and at the time, I had no savings to get off the Island, let alone pay for an abortion.
I didn't waste time. I wanted to be rid of it. I confided in my sister and we thought of all the Old Wives' Tales we knew: scrubbing the kitchen floor, doing loads of stomach crunches. I tried carrying carrying heavy weights, taking hot baths and getting pissed on gin.
If I'd been in the UK, I think someone would have given me some advice about where to go to get an abortion; what to do next. My sister was six years older than me and she would have heard of clinics like Marie Stopes.
But as it was, we were on our own, stuck on the Isle of Man with no money to get off.
My GP was really nice. He said, 'You understand abortion is illegal but girls in your position go to a clinic in Liverpool and have an abortion done privately. I assure you that it won't go on your medical records – only that you are pregnant.
If you choose to have an abortion, come and see me afterwards and I will just put, "No longer pregnant" on your records. There won't be any record that you've had an abortion'.
I took the boyfriend up into the hills to tell him – mainly so there was nowhere he could run away! I'd talked to a clinic and I knew how much it would cost for the abortion and the travel.
I was a real Manxie. I'd only ever been off the Isle of Man on day trips in a big gang of girls. Even then, I'd always been terrified of the world 'across'. I'd always make sure that I had my money hidden in my bra. I was terrified at the thought of taking the boat on my own; having to catch a train. I wanted everything to be simple: I wanted a flight, then a taxi straight to the guesthouse which I wanted to be close to the clinic.
It was going to cost a massive amount. He said his mum and dad would probably help.
It was winter then. I had to wait a few weeks. I could feel my body changing. It was so cold at Christmas. My nipples were so sore in the cold and I felt so strange. I was still living at home and my mum was being really cool with me. I'd told her and it was like, 'You've made this decision and now you're on your own'.
I flew to Liverpool on my own and found the clinic. There were about 50 other girls there, lots from Ireland, mostly like me – really nervous, looking at the others, judging them. We were all counselled before we saw the two doctors who we had to persuade we were mentally and physically unfit to carry on. It felt like we were all on a big conveyor belt.
But they were really nice to us at the clinic and they kept asking us, at every stage, whether we were absolutely sure that we wanted to carry on with the abortion.
I went back to the old-fashioned guest house. It got dark early. I'd been told not to eat anything. I just lay on my bed and I felt so lonely and frightened.
It wasn't that I was scared of the operation, I was terrified of being so alone, of the people I could hear walking along the street outside, of the other people in the guesthouse, even. They were all older than me. There was no pay phone, no-one I could talk to. I lay on the bed and cried. Just remembering how I felt then, it makes me cry even now.
The next day I went to the clinic. It was OK. The other girls were OK. We were all smoking together, nervous. I got wheeled to the operation by some salt-of-the-earth Scouser.
Right up to the minute the needle went into my hand, I was asked, 'Are you sure you want to go through with this?' I did. There was the prick of the needle in my hand, and then everything went black.
I just remember waking up and crying my eyes out; wailing. I had to stay overnight and the nurses on the ward were quite noisy. I was too scared to tell them to shut up. They'd all been really nice though. But it doesn't matter how nice they are, they can't replace the people you know. If I'd been on the Isle of Man, my sister could have been there. I really needed familiar support and familiar surroundings that I didn't feel threatened by.
But at the end of the day, if you're working class and Manx then even if you can scrape the money together to go away, no one else can afford to go with you. You're on your own.
The next day, I flew back to the Isle of Man. I got home and I cried. Mum just looked at me.
I've been to university now, got a doctorate even – and maybe that was my only chance to have a baby. But I've never regretted it. I wouldn't have passed my A-levels, I wouldn't have gone to uni. I would've been a bitter person and I would've resented the child.
I was immature and I wasn't equipped to be a parent. I think of myself as still being a child at that age. But it's not that I didn't think about what I was doing. It wasn't a decision that I entered into lightly.
If I could have had an abortion here, would I? The Isle of Man is still a gossipy place but someone would have been bound to find out. But I would've liked that choice. It's about choice, having a choice.
Abortion is an emotive subject – and rightfully so. Since my teenage years, I've studied moral philosophy and had time to reflect on what happened. At the end of the day, you are snuffing out a life. But if you've ever been in that situation yourself, sometimes it is the right thing to do. I don't regret it, I'm not ashamed about it.
But I am discreet.

Hon. Members, abortion is an emotive subject but let us today put ourselves in the shoes of girls and women who feel, for their own personal reasons, that abortion is the choice they must make.

Thank you.

The President: I call on the mover to reply, Mr Henderson.

Mr Henderson: Gura mie eu – *(Interjection)*

The President: The Lord Bishop.

The Lord Bishop: Eaghtyrane, gura mie eu.

I would I think offer my thanks also to Mr Henderson for moving the Bill; to Mrs Poole-Wilson for seconding it and for her reflections on the implications of what you might call the 'purist' approach, to which I might perhaps come back, if I may.

I thank Dr Allinson for moving the Bill in the first instance and for all the work that has gone into that; and Mr Connell, the drafter, for his work, also.

I thank the Hon. Member, Mrs Sharpe for that story just now, for that shocking account of the situation of that Manx woman, not very long ago. Clearly, no-one would wish such a situation to prevail; no-one would wish us to live in a world where such a situation was the reality. But the Hon. Member used the word 'choice' and I think my concern as we come to this Second Reading is just to be sure that our understanding of the issue is wider than the question of personal choice. The other thing that strikes me from the Hon. Member, Mrs Sharpe's account is that there was no engagement with the reality of the life that did not survive within that story; we are were asked to put ourselves in the shoes of the woman whom the story describes but not to imagine what the reality and the nature is of that life that in that case did not survive.

There are always many ways of looking at any issue of moral and ethical significance, and there may in many cases be two ways that begin by being diametrically opposed; and the task of those who seek a solution is to seek common ground where those diametrically opposed views may move together and where you achieve a position that at best could be described as consensus, and you can draft your legislation and find a way forward. There are certainly two ways at least of looking at this issue. There are many more, and most of them have been covered in our debate and our discussion that, as we come to the Second Reading, my question remains as to whether we have given due regard to both of those lives. Not both sides of the question, but both lives involved in it. My question remains as to whether we have given due regard to both of those lives and whether we have in reality seriously considered the nature and the status of the junior life.

We have the Bill as it comes to us from the House of Keys and it has been significantly amended in that House, and our task as a Council is now to consider whether it is appropriate legislation. The Bill was amended many times in the Keys; many other amendments were raised but not carried. Some were carried by a smaller margin; there was a difference of opinion over the definition of the trimesters. And the Bill was not passed unanimously at Third Reading.

The Keys did speak clearly, but not with a single unanimous voice; and acknowledging the subsidiary role of this Council, and valuing the principle which governs that, it seems to me that in the light of the context in which this Bill comes to us we have a duty to test it for ourselves through debate and question, and proposed amendments; and, as the Keys did, through the witness of subject matter experts. If we are to pass this Bill then we need to have ownership of it and if we are to own it we need to understand it and to inhabit it.

My task, Eaghtyrane, is to challenge us as a Council and to ask us whether we are so sure of this legislation, of its principles and its implications, as to be able to accept it as it is. Or whether, even at this stage while we still have time, there is greater scrutiny required – scrutiny at close quarters, scrutiny of the detail, and scrutiny at a distance looking at what this means for our understanding of human life, and compassion, and care.

I have to ask myself how I can approach a subject of this immensity; and only, surely, with absolute and utter humility, acknowledging that even as a mature human being, I have neither the reasoning mind nor the sentient heart to be able fully to perceive the reality of what this Bill seeks to do. It takes us beyond what any one of us can fully understand. So we need the perspectives of others to guide us; and we need to be prepared to enter as far as we can into the point of view of

those with whom we might disagree – with whom we might deeply disagree. So in my case, for example, I need to acknowledge my own limitations, my context and my circumstance.

I am male, I am not a woman. I said that at the First Reading but I think I need to say it again because it is a significant limitation on my perception of this issue. It cannot, for example, take me fully into inhabiting the story that the Hon. Member, Mrs Sharpe has told us. But if I acknowledge that limitation then perhaps it does help me in my perception of the question. There is indeed perhaps something deeply unattractive about one group of people telling another group of people how they should behave and what their principles should be. But it is perhaps more acceptable if I can say to that other person, I cannot fully understand what your situation is but I wish, as far as possible, to enter into it and to see how I can best support you in the challenges that you face.

I acknowledge that we need new legislation; clearly that is the case. Our 1995 Act gives us an unsatisfactory outcome by allowing, or permitting, in one sense yet essentially also stigmatising and marginalising those women who seek its services. I have the deepest concern for a woman who has to make such a decision, or who faces such circumstances. And I repeat that also I have the deepest concern for any woman who has to make such a decision or who faces such circumstances. I also have the deepest concern for an infant life which already exists and is beginning to develop and grow.

As Bishop, I have a deep concern for everyone who lives on this Island, for those who welcome this Bill as it stands; for those who are troubled by it; and for those who struggle to understand it. I very much want this Island to be a place of moderation and mediation, and a place where minority views are acknowledged and are given consideration. I am clear in my mind that we sit firmly within that spectrum. But perhaps part of my challenge today is to ask us whether we have done everything we can – and everything we should – to listen to the voice of our neighbour.

As Bishop, I have to have a care for people of faith, for people of all faiths to some degree, and I need to be able to offer to them a context for legislation that determines how we perceive one another; and particularly how we perceive the most vulnerable in our midst. I need to ask myself whether I can vote for this Bill. I want to; I want to keep faith with the process as we move towards final reading. But to do so I need to have some degree of confidence that we can shape it towards a greater universal acceptability and at the moment I am not sure that I have that confidence. I therefore propose at present to vote against this Bill at Second Reading although, as always, I remain hopeful that we may be able to make progress towards greater safeguards of that second life; that unborn, yet authentic, human life; that 'junior life' as I have called it.

Having defined that context, having defined my own limitations, I then need to identify a means of approach and to ask: what is the presenting question that gives us direction or access towards a solution? There is the moral principle and there is its practical outworking, and there may sometimes be a difference between those two things. That is to say that, as with any ethical question in the real world, there needs to be an acceptable balance between principle and practicality. And that, I do not think, is compromise; I think that has to do simply with what you could call *realpolitik*, what it means to live in the real world and to acknowledge the reality of people's lives within a moral and ethical framework.

There might, for example, be a similar question in some people's minds, if I can take an illustrative example, about vegetarianism and meat eating. You could have a principle, a moral question as to whether, for example, there is a strong case not to eat meat but to be a vegetarian. But your view on that might actually be moderated by the scale, because there may come a point whilst the principle itself is acceptable the scale that it has reached is less so. And so, for example, in my own instance my view on that matter is informed by the fact that the amount of chicken eaten I think in the United States and the Western world now is approximately 100 times what it was at the time of the Second World War. And out of the scale of that, an ethical issue arises further.

The Hon. Member of the House of Keys moving this Private Member's Bill, Dr Allinson, has said that he hopes that the effect of this will be to reduce the number of abortions. I know that is his intention and for that I commend him unreservedly. But I have to be sure in my own mind that that is what will happen.

In the recent Irish Referendum there were many stories of injustices and of cruelty imposed upon unhappy and pregnant women, and the same was true in the discussion which resulted in the Abortion Act 1967 in Great Britain. But those legislators imagined always that that would be used in limited circumstances, they did not envisage anything like the figure of 9 million lives that have been aborted through that Act since that date. And an Act which has given rise to its own industry – Britain's largest abortion provider is the British Pregnancy Advisory Service which charges taxpayers via the NHS £670 for a surgical termination. In 2016, the figure in England and Wales for the number of abortions was 190,406, providing an annual income for BPAS of almost £30 million – and that, I would suggest, is most certainly a fact that carries ethical implications.

Neither did the legislators of 1967 imagine, I think, that now 50 years later we would still be so far from resolving those social failures from which unwanted pregnancy arises. Did they imagine that 50 years later in some parts of the United Kingdom we would still be so far from a climate of positive and respectful, responsible relationships? That we would still be so far from raising the aspirations of young women in areas of deprivation? We would be so far from offering to young men a vision and a culture of relationship that is not self-gratifying or exploitative?

So where is the starting point then for our discussion and our way into this? Where do you find your moral compass? The impetus for this Bill, for this legislation, comes from those with most to say about it. Rightly, and wrongly, it is the voice of the mother that is being heard. It is not to any great extent the voice of the medical professional who will be tasked with doing this work; and it is certainly not the inaudible voice of the baby, the inarticulate yet authentic voice of the junior life.

So these are the questions that seem to me to be really important as I approach this issue. Is the foetus a baby? The answer may often seem to be yes, if it is wanted; and no, if it is not.

If I were to go to a young woman who had been desperately hoping for a child, had been desperately wanting to conceive, had perhaps put large amounts of her savings into that process – not to mention the emotional and spiritual strain that goes into it – and suddenly rejoiced in the fact that it had been confirmed that she is eight weeks pregnant. If I were to say to her, 'That's not a baby that you are carrying' that would be absurd – that would be an absurd and irresponsible statement to make. In that woman's mind, that is the baby that she is carrying. And yet in, for example, the story from the Hon. Member, Mrs Sharpe that second life is not described in those terms because simply it has the misfortune of being conceived in unhappy circumstances.

So I ask again: is the foetus a baby? Whether it is wanted or whether it is not. And out of that we have to derive our question of 'personhood' – what it actually means to be a person. Perhaps at this point one distinguishes two approaches to that, as highlighted by the Hon. Member, Mrs Poole-Wilson. There is the purist approach, or I suppose what you might call the 'absolutist' approach and presumably if you take that then you say 'never' or 'always'. If you take the absolutist approach then abortion is never possible or indeed it is always possible right up to term.

But again, we live in the real world and, for example, if I speak on behalf of members of faith communities I can say that as a Catholic Christian I can take the view that life begins at conception. But I also need to acknowledge, not just the reality of the morning-after pill but the reality that the human reproductive system is naturally very wasteful; and not every spontaneous early abortion must necessarily be a tragedy. But there is a world of difference between acknowledging those natural realities and seeking to control or manipulate the greater natural processes of life and death.

So I may prefer not to be a purist or an absolutist, but to take the other position which is that of the 'gradualist', and say that I then need to understand that as this goes through a process of gradation, of gradual stages, I am going to need to make decisions. I am going to need to say, what is the difference between 12 and 14 weeks? What is the difference between 22 and 24 weeks? And why am I taking those figures in the first place? And what might be the difference between 24 weeks and 26 weeks, and so on? So I pose those questions; I pose them to challenge us. I pose them as some of the amendments that I have tabled for today, and we will perhaps look at them when we come to the clauses stage.

The other question that seems to me important is what is the value or the currency of the theory of natural law, in the study of moral and ethical questions? Natural law will say to us that as we look

at the world around us and its natural processes, we can establish certain truths; we can establish certain observed things that are so clearly observed as to be truths. And so, for example, we can say that in any society that has been known to anthropologists, it has always been the case that parents are honoured by their children. And therefore from that it is legitimate to deduce the fact that the role of parent to child is an honoured relationship and one for which children have always felt themselves called to be grateful.

Now that is a working example, simply to say that one can deduce those definable and observable truths from the world in which we live. But that would also have something to say, I think, about the relationship not just from child to parent but from parent to child. And my deep concern also, as one who is engaged in the work of pastoral care, has to do with the pastoral implications that arise through abortion – not just through abortion that is available readily on demand, but actually through *any* abortion. In other words, to say that that relationship as far as I can understand it from the perspective of not being female, that relationship between a woman and her child is so utterly profound, that if it is broken in disturbed circumstances there will be pastoral issues that arise from that. And they may be pastoral issues that are unrealised at the time that may surface 10 or 20 or 30 years later. But one way or another that will cause deep concern.

So for me, the point about natural law is that it explains something about our relationships to one another, and particularly to those intimate relationships within a family; and the issues of deep and profound anguish that occur when those are broken in disturbed circumstances.

So when can you justifiably thwart or frustrate the natural process? That is the ethical question. And can you really do so, when the only fault is that a life has been conceived in the wrong circumstances, or simply in inconvenient circumstances?

So where now is the right and where is the responsibility? Is personal autonomy really the highest moral good, the idea that it is justified if and when I want it? And as we said last time, at First Reading, there is this received understanding within Western social thought that there has always been a foundational right to life – unborn life, the end of life, crime and punishment and the death sentence, and the case for war and the conduct of war. We need to be sure, we need to be absolutely sure as a Council that we are not casting this out, and that we are not redefining the essence of life as merely a private or a moral healthcare choice.

Can we say that the unborn child is indeed a life, with that same fundamental right?

Mr President, to assist us with that question I would like Council to have the opportunity to hear from Prof. John Wyatt who is sitting in the public gallery.

The President: Thank you, Lord Bishop.

Arrangements have been made for a microphone to be placed in front of the witness. Thank you.

Could I first of all ask you, sir, to state your name and position for the record, and then I will invite the Lord Bishop to take us forward.

Prof. Wyatt: Thank you very much, Mr President.

It is a privilege for me to be able to address yourself and the Hon. Members. My name is Prof. John Wyatt. My official title is Emeritus Professor of Neonatal Paediatrics at University College, London. I am a specialist in the medical care of newborn babies, including extremely premature babies. I have also had wide experience of caring for babies with major abnormalities including life-limiting abnormalities, and in counselling parents following a diagnosis of abnormality prior to delivery and discussing the options with them. I am also very interested in medical ethics, and teach medical students and doctors in the area of ethics; and I am a member of the Ethics Committee of the Royal College of Paediatrics and Child Health.

The President: Thank you, Prof. Wyatt.

I will invite the Lord Bishop to lead off, but all Hon. Members will have an opportunity to ask questions of the witness.

Lord Bishop.

The Lord Bishop: Thank you, Mr President.

Prof. Wyatt, I have invited you to give oral evidence today in relation to a range of issues to do with the status and nature of the unborn child, or foetus, or product of conception. I was going to begin by asking you to set out your credentials in this regard, but I think you have already done that. Is there anything further to that that you would wish to add?

Prof. Wyatt: No, I do not, thank you.

The Lord Bishop: Thank you.

Prof. Wyatt, according to the BBC, 21 European countries have 12 weeks' gestation as the first point for restricting abortion, including Sweden, Germany, France, Italy and Spain. And that is, I understand, the initial time limit which Ireland intends to introduce. Only Romania has 14 weeks as the first restriction. The Isle of Man Bill proposes abortion on request up to 14 weeks with no necessary involvement of a doctor.

What do you see as the logic of 12 or 14 weeks; and what might be the implications of an initial restriction at 12 weeks, as opposed to 14 weeks?

Prof. Wyatt: Thank you.

I would point out that my main area of expertise is as a paediatrician, I am not a specialist gynaecologist, and there are a number of technical questions particularly related to the risk of abortion related to gestational age. In principle, I understand that the risks of a medically supervised abortion increase as gestational age increases. In England, as we have heard, the majority of abortions at early gestational age are carried out by the charities – and particularly the British Pregnancy Advisory Services, BPAS – and in their guidance they have a strict distinction between a 10-week pregnancy. They say that below 10 weeks a medical abortion can be carried out at home although the pills are given within the clinic; beyond 10 weeks, they say clearly that supervision must occur, the abortion process must be supervised in the care within the clinic, where medical and nursing supervision is available. I understand this is because of the greater risks of complications and also the psychological consequences.

I think a medical factor which is very important for Hon. Members to be aware of is that the determination of gestational age is not an exact science. It is something which depends on ultrasound scanning and the skill of the ultrasound operator is critical; and in my professional experience even in the major centre of excellence it is not unusual for gestational ages to be inaccurate up to two weeks. Therefore the possibility that, for instance, a foetus who is said to be 13 weeks could in fact be 15 weeks, and what the implications would be of delivery under unsupervised circumstances, the risks of failure of the abortion process, the risks of haemorrhage and bleeding; and also the psychological consequences, for instance, of delivering a foetus into a toilet bowl – a recognisable child – at home, and what kind of implications of social support and so on.

So I wonder if I could make the suggestion for Hon. Members that actually receiving detailed advice from an experienced gynaecologist from BPAS, for instance, who undertakes these procedures would be helpful, and may therefore need to be reflected in the primary legislation of this Act.

The Lord Bishop: Thank you very much, Prof. Wyatt.

The House of Keys did not discuss possible side effects of abortion, leaving that as with most medical procedures for patient and doctor to balance the risk or the benefit. But the Bill does include the compulsory provision of pre- and post-abortion counselling. Is there any emerging evidence of harm from abortion that should be taken into account when framing our abortion law?

Prof. Wyatt: There have been a large number of research studies looking at the long-term sequelae of women who have had abortions and so on, and this is a highly contested and

controversial area; and to me, as somebody who has read a lot of this evidence, one of the slightly depressing things you find is that when investigators who clearly come from a pro-choice perspective undertake scientific research they find findings that in fact there are very low incidences of complications, and that it seems to be a relatively minor problem; and when investigators who come from a pro-life perspective undertake almost identical research they come to different conclusions that there are much more significant sequelae and some of them are very long lasting.

I think this just illustrates the fact that everybody is coming from somewhere, and that therefore one has to deal with a certain amount of caution, confident statements about outcome, because so often these reflect the prior presuppositions. Even when scientific research is done, because of the way that it is necessary to assess and balance scientific evidence, it is inevitable that prior beliefs and prejudices will influence the way that scientific research is done.

Certainly, anecdotally, my wife is involved in a counselling service for women who suffer post-abortion distress, and anecdotally she has many clients, some of them who are distressed and go through prolonged counselling because of an abortion which took place 20 or 30 years previously. And that is anecdotally my experience too, in talking to people. So I think perhaps the rather blithe assumption that this is a minor procedure and that people just get on with their lives, is not the case.

The Lord Bishop: Thank you, Prof. Wyatt; and clearly that chimes with my own pastoral experience as I just expressed it.

For an abortion between 15 and 24 weeks, under clause 6(7) the doctor has to state in good faith that according to the woman there are serious social grounds justifying the termination of the pregnancy.

Do you envisage difficulties for doctor or woman under the present phraseology?

Prof. Wyatt: Well, as a medical practitioner trying to interpret this kind of wording, it is certainly very difficult and open to interpretation.

What is the definition of a serious social ground? I know there has been some attempt to provide a form of words to help practitioners, but in the end this is a highly subjective assessment – similar to trying to define what a serious impairment involves, that what is to one person catastrophically serious is to another person relatively trivial. I think the way that the Abortion Act has been interpreted in England and Wales suggests that practitioners feel free to put their own interpretation on the words. And I think, inevitably, my fear would be that in putting a ground like that one is opening the possibility of these words to be interpreted in ways which the original Hon. Members never intended.

The Lord Bishop: Thank you.

Can I ask, Prof. Wyatt, what do you see as the rationale behind the 24-week limit in England and Wales for most abortions?

Prof. Wyatt: When the Abortion Act was initially passed in 1967, the abortion limit was 28 weeks, and it was illegal to undertake an abortion beyond 28 weeks. It is clear from the original discussion in parliament, that 28 weeks was taken because it was at that stage very unusual for a premature baby to survive if born alive below 28 weeks, and it seemed to be clear that the original legislators wished to put clear blue water between the period when a baby was possible to survive and the period when abortion could be performed.

When the Abortion Act was revised in 1991, I think it was, the limit was taken down to 24 weeks but there was also, because of advances in the care of premature babies – which was again taking place in 1991 … and that limit of 24 weeks, except in the unusual cases of foetal abnormality or risk to the mother's life, has persisted since 1991. There has been debate about whether or not the abortion limit should be lowered from below 24 weeks, and there have been very significant advances in the care of premature babies since 1991. Therefore I personally feel that for this House to bring in a 24-week limit now in 2018, reflecting effectively what has happened on the mainland in

1991, is open to question because of the advances in the survival of babies below 23 and 22 weeks' gestation.

The Lord Bishop: Thank you.

And perhaps related to that, can I just ask … I mean, given that survival outside the womb has in the past been a yardstick to determine that 24-week limit in England and Wales, can I ask about your experience in University College Hospital and the latest research evidence for the survival of extremely premature babies?

Prof. Wyatt: Well, there has been a great deal of research into the outcome of extremely premature babies, both in the UK and across the world; and as you will understand, the survival chances of a child born at these extreme limits of viability depends critically on the quality, and the training, and the expertise of the unit in which they are born. Therefore you would expect survival to be much higher in major university centres, such as the centre where I work, or have worked – I have recently retired from the NHS – and also it depends on the ethical attitudes of the staff. There is good evidence to show that if the staff take a more interventionist attitude to the survival of premature babies, then lo and behold the survival is much higher, whereas if they take a more *laissez faire* attitude then survival is worse.

In our unit at UCH in Central London, the survival of babies at 23 weeks is over 50%, and the majority of those will survive without severe disability, and survival at 22 weeks is certainly recognised and relatively common. The latest nationwide study that was done in the UK was done in 2006, and that was an EPICure study, and that pooled together results from all over the UK, including some much smaller centres. But that showed on average that there was survival of 23 weeks of between 10% and 20%.

Again, I would just point out that it is probable that if people from the Island were travelling to the UK, to England, for medical treatment – I understand they frequently go to Liverpool. Liverpool has a major neonatal intensive care unit and the survival of premature babies there will be approximately similar, I would guess, to what is happening at UCH. So I would suspect survival of approximately 50% at 23 weeks.

The Lord Bishop: Thank you.

Can I ask, Prof. Wyatt, also: would you be able to offer any thoughts on the capacity of the foetus to experience pain?

Prof. Wyatt: Well, this again is a highly contested and controversial area and of course at a sort of basic philosophical level it is not possible for us to know what it feels like to be an unborn baby, or a foetus, any more that we really know what it feels like to be a newborn baby.

One of the factors we can do is that when we care for a baby at 22 weeks, for instance, or 23 weeks, we can see that that baby is highly responsive to the environment, that they respond to painful stimuli, they screw up their face, they try to cry. They respond to sound and touch and light. And there have been studies using ultrasound showing that the foetus at equivalent gestational ages has the same kind of responsivity. We know that a foetus as low as 18 weeks has a stress response in response to a needle being inserted. We know that foetuses respond to sound and light and touch in the womb. They go through periods of sleep and wakefulness, particularly in the third trimester.

So the old idea that the foetus or unborn baby is a passive occupant of the womb is very old-fashioned. We now understand the foetus is a much more active person, individual, entity – I am searching to use words which are not loaded. And one of the interesting things about this whole area is the way that even the language we use is loaded – it is philosophically loaded – whether we talk about a foetus or an unborn baby, we have immediately taken a stance and it is not possible to find neutral language. I am struck by the fact that when we talk to mothers, even if professionals are using studiously professional language, nearly always the mother will talk about 'my baby' even at a very early stage of gestation.

So the scientific evidence is that the foetus/unborn baby is actively a participant and engaged in responding to its environment.

The Lord Bishop: Thank you.

And rising from that, a question would be how abortion law might take that evidence into consideration on its humanistic principles?

Prof. Wyatt: Well, the fundamental question, the moral question, is how we regard this being in the womb and to what duties do we owe. So the real moral question is not when does life begin, because it is clear that this being in the womb is living and it is clear that it is a human life. The real question is when is there a person that we have a duty to protect? When is there a person to whom we owe duties?

I think when you frame it like that you realise that although the scientific evidence can help, it does not answer the question, because ultimately that is a question of philosophy and theology, or of a world view. I think the challenge of course in a pluralistic society, is how do we protect the common good? How do we help one another to find the best way?

What I do see is the state of the current law in England causes a great deal of confusion and concern, because of the juxtaposition that in the very same hospital we are saving lives and seeing these tiny babies survive, who are much loved and cared for and celebrated by their parents. And literally one floor away in the hospital there are sophisticated procedures going on which are destroying the lives of sometimes beings who are more advanced, bigger and stronger and tougher than the ones we are saving one floor down. And as somebody who has to talk to parents with a foetal abnormality sometimes at a very advanced stage of the pregnancy, when the mother first discovers that it is even legal or possible to have an abortion at this advanced stage she is frequently shocked and horrified.

People just are not aware of the reality that abortions are taking place at these advanced gestational ages. But then the parent finds themselves in a very strange psychological bind because they feel now, because that option has been opened to them, they feel a crushing sense of responsibility. A number of parents have said to me, 'Actually you know, doctor, it would be much better if you hadn't told me this, but now that I am told there is an option of having an abortion at this advanced stage of the pregnancy, I feel in a double bind – I am either personally responsible for bringing a disabled child into the world, or I am responsible for ending the life of my unborn child, and I can't see how I can possibly make that decision'.

The staff also feel the pain of the current situation of this sense of ambiguity about the life that they are dealing with. So again these are the struggles we have because of the current legislation in England, and it is just important that Hon. Members are aware of what the implications are.

Perhaps if I could just go on and say one of the other factors – and I am sorry again this is all rather grisly – but the possibility in the more advanced stages of a pregnancy of the baby being born alive is a significant possibility. I have been involved in tragic cases where a failed abortion has happened and a baby has been born alive and resuscitated and then all kinds of complex challenges have been created. As a result, the guidelines in the UK are that procedures should be performed to ensure that the unborn baby, the foetus, is dead before delivery, which involves injecting under ultrasound guidance a lethal poison into the foetal heart and ensuring that the foetus is dead before the abortion procedure; and this procedure carried out under ultrasound guidance, sometimes with the parents watching, or with the father of the unborn baby and so on – is an extremely painful and distressing procedure, and it is perhaps not surprising it has been shown that the psychological and long-term psychological distress, and sometimes psychiatric problems are greater in these conditions than they are in the abortions done for the so-called social reasons.

The Lord Bishop: Thank you.

You have taken us through some very significant material there to do with the foetus essentially as a sentient or capable of feeling, a human person. You have given us your views as a medical ethicist on the philosophical basis for valuing human life.

If one were to look at the aspect of this legislation that has to do with disability, would you say that there are any circumstances in which we could value a child with some degree of disability, *less* than a so-called healthy child?

Prof. Wyatt: Well, again this is an issue which is highly contested and it seems again that society is going in two different contradictory directions because, as we all know, there is much greater emphasis on the rights of disabled people in society, and the requirement that they should be treated in exactly the same way and have exactly the same rights. Certainly once a baby is born we feel strongly as paediatricians that we should fight for the rights of our disabled patients; we should ensure they get the very best possible care and treated exactly with the same rights as any other child. And yet before birth it seems that although we would regard it as abhorrent for a healthy unborn foetus to be destroyed close to term, we accept that it would be appropriate in the case of this in the wording of the Bill, a 'severe impairment', I think it is. And I think that there are many people, including especially disabled people, who feel that this is some kind of discrimination that the life and worth and value and significance of this being is being treated as less than the life of a healthy child. And again of course there are extremes, the subjective question of what is a severe impairment? Is for instance, a cleft lip and palate, which might cause a reduction of life expectancy even when surgically treated? How would that be regarded under the Act?

Every child is different, every disability is different, and trying to find a rigid cut-off point at which you say this one qualifies for a late abortion and this one does not qualify. Again how practitioners make that decision is very problematic.

The Lord Bishop: Can choice to abort become a duty to abort in the case of the disabled?

Prof. Wyatt: Well, I think that parents often feel a deep sense of responsibility. They feel that because of this huge amount of knowledge that is available about the foetus – they go on to Google and do a huge amount of searches, get a large amount of evidence. Many parents have expressed to me a deep sense of responsibility, that they feel they are responsible to ensure that their child does not survive because of a severe disability; and some have expressed to me, 'It would be much better if I didn't know – once you have opened this Pandora's Box I feel a sense of duty'.

Certainly I have heard it said, for parents, that 20 or 30 years ago if you were pushing a buggy clearly with a disabled child in it, people might say including something like Down's Syndrome – people would say, 'How sorry I am to see that'. Now it occurs when you are pushing the buggy and someone says to the mother, 'How could you? How could you have chosen to bring that child into the world?' So that is the implication, the unintended implication sometimes of this kind of legislation about disability.

The Lord Bishop: Thank you, Prof. Wyatt.

Well, I think my final question to you, if I may, refers to something that I will come back to later on also, which is to say that the Bill allows authorised persons including pharmacists to prescribe abortion pills to be taken, and that could be at home. What legal measures would you advise to ensure the safety of the woman?

Prof. Wyatt: Well, I would just reiterate again that this is really not in my area of expertise and I think I would defer to the other experts on that.

The Lord Bishop: Okay, alright, thank you.

Prof. Wyatt, thank you very much.

Eaghtyrane, I have no further questions for Prof. Wyatt, so perhaps if other Hon. Members would like to?

The President: Thank you, Hon. Member.
Does another Member wish to speak?
Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President.
And thank you for the evidence you have provided, I appreciate that.
We are all well aware of the Bishop's ideological standpoint on this subject matter. What are your personal beliefs, because as you say empirical research has historically reflected the beliefs of the individuals?

Prof. Wyatt: Well, that is true, we all have personal beliefs and my belief is that I am a Christian and I believe that human life is precious and to be protected. That does not affect the scientific evidence in terms of survival and so on. The survival figures I have quoted, for instance, are published in peer-reviewed scientific journals including the data from UCH. But clearly when we are talking about subjective issues, about some of the philosophical issues, then yes, everybody is coming from a particular perspective.

Miss August-Hanson: So you will have followed the abortion debate in Keys, I would imagine, or had a look at the legislation and the Bill that is being proposed. What are your thoughts around that generally then, certainly in terms of the themes that have been put forward in Keys?

Prof. Wyatt: Well, I understand the basic themes and the way it is put forward, and in many ways it is an attempt to put forward the principles which are in the way that abortion is carried out in the UK, in England and Wales. I think as I said before, because you have the benefit of passing legislation in 2018, whereas the legislation in the UK is really based on 1967 and amended in 1991, it is possible for the legislation here to reflect more the available evidence now in 2018.
I would therefore support the amendment of reducing … I think the 14-week limit is very strange, if I may say so. It is completely out of line with what is happening across the rest of Europe and I do not believe it fits with the general standards of what is happening in other legislations. I think the 24 weeks is the same as what we have got in England, but personally I would reduce it and would support the amendment to reduce it to 22 weeks.

Miss August-Hanson: For clarity, in your experience as a paediatrician in the UK in law, but for you when does the foetus have rights?

Prof. Wyatt: In *law* the foetus is not recognised as a legal person until literally the moment of delivery; and you do get this slightly bizarre thing that five minutes before, the foetus has no rights, and five minutes after this is a full member of the human community who is protected by exactly the same laws, and national and international conventions, and guidelines. So from the moment of delivery I, as a paediatrician, have a duty of care to care for this individual who is protected by this panoply of national and international legal rights.

Miss August-Hanson: But for you, yourself, when do you believe that it should have rights?

Prof. Wyatt: Well, I am a clinician and not a lawyer and I understand the whole problem about legal rights. I understand that the idea of a legal conflict between the foetus and the mother opens up another new can of worms. But I would reiterate that I do believe the foetus is a human life that deserves respect and protection and care, which is actually what most – in my experience – lay people intuitively respond to, and therefore that our law should reflect the fact.

I mean, it is very striking that the way the law in the UK – the crime of procuring an abortion by violence – when a pregnant woman is attacked and as a result an abortion occurs, that is regarded by the law and by society as particularly horrific, precisely because not only is it an assault on another human being but there is the loss of the life that occurs as a response. So in that respect the law recognises the significance of the unborn life, and I think it is therefore important that abortion law reflects that same kind of concern about the significance of the foetal life.

Miss August-Hanson: Of course, you describe an attack there. We are talking about choice in here. So what is that difference there for you?

Prof. Wyatt: Of course this mantra of choice is very much at the heart of modern society, it is the heart of the NHS and patient statutes and all the rest, but it does lead to a very strange position. To me, nothing illustrates this more than what happens in the ultrasound department. When it is clear that here is the scan – the person that is scanning the baby – the most important thing that the ultrasound doctor, or sonologist, has to determine is whether or not this is a wanted pregnancy. If it is a wanted pregnancy the screen is turned to the mother and you know it is, 'Oh look at his little arm, he's waving at you', and, 'He looks just like Dad', and all this kind of discussion; and, 'Do you want the pictures?' and 'I'll try and get the best shot'; and 'We're going to put it in the photo album', and so on.

If this foetus is not wanted, the screen is turned away and the whole discourse changes, 'Well, while the pregnancy is probably about 11 weeks and it is appears to be developing normally', and yet nothing has changed. This being is exactly the same.

Are we really saying that the fundamental significance of this being depends entirely on whether this is a wanted being or unwanted? We do not say that in any other area of human life. We do not say that about a child, we do not say that about an old person. We do not say it at any other stage, but here it appears choice has become the ultimate mantra – a value that determines the value of a life.

Miss August-Hanson: So just finally from me, would you say that your beliefs in terms of abortion align with that of the Bishop?

Prof. Wyatt: I am not very well known to the Bishop so I am not at all sure, to tell you the answer. I am here not really to talk about my beliefs about abortion; I am here to give evidence from my area of expertise.

Miss August-Hanson: Yes, but you have said that empirical research and evidence that has been provided in the past has been based on … historically, there is some reflection in terms of the beliefs of the individuals that have undertaken that research.

Prof. Wyatt: Yes, I was talking particularly about the long-term psychiatric outcomes of abortion. It is certainly not the case with the evidence I have presented about outcome, about survival, about incidence of disability. These are very hard, objective, empirical evidence and I stand by the evidence I have been given; and I suspect that a paediatrician coming from a completely different philosophical position would also agree on the figures.

Miss August-Hanson: Thank you very much, I appreciate that.

The President: Thank you, Hon. Member.
Mrs Hendy.

Mrs Hendy: Thank you, Mr President.

Prof. Wyatt, your testimony today has been very moving and very thought provoking, and I thank you for your contribution today.

Is there a gestational age that in your professional opinion you would safely put as a cut-off, so we could be satisfied that there is no human entity to be protected? At what stage would that be?

Prof. Wyatt: I think that it is not possible for science or medicine to answer that question; that ultimately what science and medicine can do is it can take your description of the way that this being is responding, or what its capacities are as much as we can – we can talk about size and movements and so on, and brain development. But science cannot answer the fundamental moral question about: is this a human life? Or what is the significance of this human life?

I mean, just to take an example, if you were to take a tiny baby born weighing maybe one or two pounds and compare that to a rugby-playing adult, you would say, 'Well, it's obvious that the rugby-playing adult scientifically is so much stronger and so much more powerful'; and so you would say, 'This being is worth so much more than this tiny pathetic little baby'. And yet if this was the son of the rugby player, as we have had the situation in our neonatal unit, then they would value these lives very differently.

So it is not a scientific question, it is ultimately a question of our moral understanding of what it means to be human. Many people have said that the real moral power of a society, the value of a society, is how it treats the most vulnerable; how it treats the weakest; how it treats those who do not have a voice. And certainly I think there is a lot of strength in that, and I think there have been great advances in society in caring for very weak members – for victims of child abuse, for battered babies and for people with dementia, and so on.

So I think there is a duty on society to think and care particularly for its most vulnerable members.

Mrs Hendy: Thank you.

And just one more question: you referred to your wife and the counselling she has done for women who have had historic abortions, but they seem to relate to a period that was a considerable time ago. Would you attribute the distress maybe that they were experiencing … because the circumstances and the climate surrounding abortion in those times were different than it might be now?

Prof. Wyatt: Well thanks; it is a very difficult question to answer. I think it probably is true that … I mean, we heard this very sad story earlier about the young lady here on the Island and the social attitudes which she was reflecting. I think it is true that I can think of elderly ladies who talk to me about having an abortion 50 years ago, and even at the time of the 1967 Act, and so on. It is true that social attitudes have changed but I think the *human* experience of this does not change, because one of the things we have learned about – and perhaps it is just another factor to tie in – is we now have much greater awareness of the significance of an early miscarriage.

So previously I think generally society, and certainly doctors, would tend to dismiss the experience of having a miscarriage as being of no significance at all. This is just a trivial medical event. Whereas now, I think we are much more aware of the long-lasting psychological consequences, particularly when a baby is wanted and so on, and it is now becoming much more common for people to sort of celebrate their miscarriage, sometimes even to name a child that was lost, to have some kind of ceremony and so on.

So I think this again is just reflecting the human experience of pregnancy as something that is very profound. My wife, who counsels women as sensitively as possible, and she is not at all aiming to cause pain, but she does say that it is often what counsellors call a 'complicated grief' – so, 'There is a deep grief at the loss of a life, but it is also sort of complicated because I was involved in the decision-making' – and it is those factors which then sometimes cause longer-term psychological issues.

So although one would assume that an abortion carried out at, say, six weeks would be psychologically much less significant than an abortion carried out at 20 weeks, I think actually the evidence is not there. I suspect that the psychological sequelae may be actually quite similar. Though medically abortion at 20 weeks is much more risky, at a psychological level I suspect they are often seen as similar. And just also to point out this is not just a woman's issue and that my wife sees a number of men, the fathers of the aborted babies, who have significant psychological issues as well. So there is always a man involved as well and again that has been an issue which has been often neglected.

Mrs Hendy: Thank you very much.

The President: Mr Henderson.

Mr Henderson: Gura mie eu, Eaghtyrane.
Thanks very much for appearing at the Bar of Legislative Council, Professor. I just want to ask you one question: are you here in your personal capacity or some organisational capacity; or are you here on your own as it were, as an invitee of the Lord Bishop?

Prof. Wyatt: Yes, I am certainly not here representing any organisation. I am a member of a number of organisations including, as I said, the Ethics Committee of the Royal College of Paediatrics, but I am certainly not speaking on behalf of any other organisation. I am really an individual who has a special interest in the issues we have been talking about; and experience.

Mr Henderson: Thank you very much.

The President: Does another Member wish to question the witness?
Mrs Poole-Wilson.

Mrs Poole-Wilson: Thank you, Mr President, and thank you to Prof. Wyatt. I must say I think it has been very interesting and helpful to hear evidence from you this morning.
I just had a couple of questions and I completely accept that you have said that your expertise is actually nearer birth and with the new young life that is born, but we have talked about the cut-off period, for want of a better expression, of 14 weeks and also the Lord Bishop has raised the idea of prescribing medicinal products to have a medical termination.
I understand that is not your area of expertise. The language the Bill uses, however, is always about 'may'. It is allowing for the potential that appropriately qualified, trained and competent individuals *may* do certain things up to a certain point. So I suppose my question for you is, bearing in mind it is not your expertise, what would you expect in terms of the practicalities of how that sort of enabling provision operates in order to deal with some of the issues we have been thinking about?

Prof. Wyatt: Yes, thank you.
Certainly, the way it tends to happen in England and Wales is that you have the primary legislation and then you have published guidelines produced by authoritative bodies, such as the NHS or the Royal Colleges or something like that, which then formulate the procedure of what will be carried out. So it would be perfectly possible to have primary legislation which says an abortion may be carried out at 14 weeks, but to have guidelines that say it can only be carried out up to 10 weeks at a person's home; beyond 10 weeks it must be carried out with the use of appropriate medical supervision and so on.
Having said that, I think there is a question of whether it is, if that was the intention of the legislators it may be better to put that in the primary legislation because it is always possible for

someone to come back and say, 'Well, actually that is what the law says and, okay, I was not following the guidelines but I am staying within the law.'

So I think the intention of the legislators is important and particularly in terms of harm, and I think by minimising harm there is again this tension here in the early abortion, there is a desire to make it as friendly as possible, in which case make it as open as possible and say, 'You can do it at home and there is a minimum amount of intervention,' versus the genuine need to protect women from harm – both medical harm from the abortion procedure going wrong and being unsuccessful, for instance, but also I think psychological harm.

I am very concerned. I do think at least if you are having an abortion in a clinic you have got trained professionals around you, whatever happens you have got someone to be there for you. I think if you are alone at home completely not knowing what is going to happen, then delivering into the toilet it just seems to me a very – I would not want to use the term 'barbaric' but – sort of an unfeeling kind of way. In general we would not do this for other medical procedures. Why is this particular medical procedure something to be done unsupervised at home?

So it then becomes very important: the precise nature of those guidelines and who formulates; are they informed by the best opinions and have they thought through the implications for the harm of the woman?

Mrs Poole-Wilson: Thank you for that. That is very helpful.

As a professional yourself, subject to your own professional guidelines, could you ever have thought of a situation where you would have gone against those guidelines professionally, even had you been able to find room within a law that would have enabled you to operate against your professional guidelines?

Prof. Wyatt: The honest answer is yes. There are occasions where I have gone against guidelines because I felt I was sufficiently experienced and knowing that I was taking a risk, that I could be potentially censored by professional bodies, but in my personal opinion in this circumstance I was staying within the law but I was doing what I felt was right.

So I think practitioners see a distinction between the law and guidelines, because guidelines in the end are guidelines, they are not always absolutely prohibitive.

Mrs Poole-Wilson: I think one of the other challenges possibly just to explore with you though is with primary legislation in order to then change the primary legislation – and we see this with the 24-week limit perhaps in the UK – it requires more primary legislation, and I suppose the benefit of guidelines is probably the ability to continually adopt and change to reflect best practice. I do not know if you have any thoughts?

Prof. Wyatt: No, I think you are absolutely right, but perhaps what I would say back to you, therefore, is that now is your chance when you are still dealing with the primary legislation; because you are quite right that once primary legislation is out there it becomes much harder for it to be amended, because the whole political process has to restart again. Whereas if you have a chance to get it as good as possible in the primary legislation now you can avoid the need to come back in turn.

Mrs Poole-Wilson: Just one other question, please, if I may.

We touched on the concept of choice earlier on and I suppose the other way to look at it though is to think about are there circumstances in which the balance of the decision would be in favour of an abortion lawfully?

So I would just be interested in, if we step away from the concept of choice but try and consider that what we are weighing up is any one individual's particular circumstances. I would just be interested in your thoughts on ...

Prof. Wyatt: Of course it is true that individual circumstances are always unique and that every person therefore has the importance of making decisions in the light of very unique circumstances. But I do not really think that changes the fundamental moral question about the value and significance of a life, because the same thing applies after birth. We do not say, 'Well, the value of this baby's life is of course affected by the fact they are in terrible circumstances' or 'These circumstances are so dire, obviously this baby's life is not significant'. We do not see that, we see the value of the life as being somehow independent both of the choices and of the circumstances. It is something which is actually inherent in the baby itself.

Mrs Poole-Wilson: Thank you very much.

The President: Does another Member wish to speak to the witness?
Mrs Sharpe.

Mrs Sharpe: Prof. Wyatt, thank you very much.

I was interested in what you had to say about parents who are told that their foetus has a disability. You say that the parents then feel there is more responsibility upon them to make a decision. Would you say that you have ever come across a parent who then decides to have an abortion because the foetus has a disability, or do you find that parents would not actually take what is in legislation as part of that equation, because surely it is about how the parent, regardless of what is in legislation, feels about the foetus or the baby growing inside them?

Prof. Wyatt: I think it is important to realise that actually legislation does play a very significant role in how people think about this, because most people are not really aware of the finer points of legislation until it applies to them. They are vaguely aware of the fact that there is an Abortion Act but really the vast majority of people will not be aware of the provisions of the Act.

I can give you an example where, because our scanning technology is increasing all the time, one of the problems is we are picking up abnormalities in the brain at a relatively late stage of gestation that we do not really know what the significance is; we know that the brain does not appear completely normal. It is not a massive thing but it is a significant thing and when we look at our statistics this means that there might be an increased probability that the child is going to have some kind of disability. It could be learning difficulties, but not very severe. We are uncertain.

The doctor feels they have an absolute duty: (1) to tell the mother that there is an abnormality of the brain – of course we are not paternalistic, we have to be honest; and (2) to tell her that according to the law it would be legal for an abortion to be carried out. The mother is digesting this bombshell. The doctor has to tell her it would be legal because if he does not the doctor, he or she, could then be sued for a so-called wrongful life if the mother discovers subsequently that an abortion would have been legal.

So the mother is now, and parents are, trying to digest this bombshell. 'I want a child but could it be the child has learning disabilities and I discover, to my amazement, that it is legal to have an abortion. If it is legal, then it must be because people feel that lives like this may be ended, because otherwise there would not be a law. So clearly the people who framed the law thought that there were situations where life should be ended if there was ...'

So that actually is factored in by parents into this question. Obviously it is not the only thing and some parents would say, 'Well, we are going to love this child whatever, and the doctors are not certain and I am going to carry on,' and a lot of parents would say that; but there would be some who say, 'Well, if there is that question and it is legal, then I suppose perhaps I ought to do it,' and so there are late abortions carried out for those reasons.

I have to say the numbers are small, but nonetheless this is the sort of troubling aspects of what this law does. Both doctors and parents get caught in a Catch 22. We, the doctors, have to tell the parents everything and we have to tell them that it is legal to have an abortion and then the parents are left with this kind of very momentous decision.

Mrs Sharpe: Thank you.

The President: Mrs Poole-Wilson.

Mrs Poole-Wilson: Sorry, yes. Thank you, Mr President.

Just to follow on from that actually, one of the key aspects in our Bill is that any woman must be offered counselling as part of this process and, significantly, must be offered information as well, in order that she can take a very balanced and rounded perspective. We have a specific provision saying that must be available from any groups who may be able to give more information about a particular disability.

What would be your thought on that?

Prof. Wyatt: I think that is very positive and I am very supportive of that.

Again, the problem is the wording: 'counselling' can mean anything and nothing. It can mean three minutes ticking a box or it can mean, as I would have, often an hour's painful discussion of all the implications with a parent, and the possibilities.

I think in the case of a disability it is always preferable to talk to a paediatrician like me, rather than an obstetrician who has no personal experience of caring for children like this. I do know that a number of women who were considering having a termination because of sometimes a life-limiting abnormality … once I described to them what palliative care of the baby would be like and how we would care for the baby and they would be able to cuddle the baby and we would make sure that the baby did not suffer and so on, a significant number of parents opted for that rather than an abortion, once they were aware that this was a possibility.

So I think it is very good that it is in there. If there is a way of saying – or these are the kinds of things that the guidelines might say – that the mother ought to be referred to see a paediatrician, if she wishes, or it is made available to her, that would be good.

Mrs Poole-Wilson: Thank you.

The President: Prof. Wyatt, on behalf of Council, I would like to thank you very much for being a witness this morning and to say we are most grateful to you, and for the clarity of your evidence.

Prof. Wyatt: Thank you, Mr President. Thank you.

The President: Lord Bishop.

The Lord Bishop: Mr President, thank you very much indeed.

I would like to turn now to another question of the implications of the Bill which I believe needs to be significantly tested, and that has to do with medical professionals and healthcare workers and the requirements put upon them. There is a clause relating to conscientious objection within this Bill, clause 8, to which I am proposing an amendment.

Mr President, to assist us with the question of conscientious objection for medical professionals and healthcare workers, I would like Council, please, to have the opportunity to hear from Dr Mary Neal who is sitting in the Public Gallery.

The President: Thank you.

If the microphone could be taken, please?

I would like to welcome you, Dr Neal, to this session of Legislative Council and to ask you for the record please, to state your name and qualifications.

Dr Neal: Certainly, Mr President.

My name is Dr Mary Neal. I am an academic lawyer specialising in medical law and ethics. My current post is as a senior lecturer at the University of Strathclyde in Glasgow.

The President: Thank you very much.

Lord Bishop.

The Lord Bishop: Thank you.

Dr Neal, thank you. I have invited you to give oral evidence today in relation to the role of conscientious objection in the Bill because I understand that this is your particular area of expertise as an academic lawyer.

You have given us your current position, but could you perhaps also set out your wider credentials within that regard?

Dr Neal: Certainly, yes.

So as I have said, I am an academic lawyer with expertise in medical law and ethics, but for the past few years my research has focused on the issue of conscientious objection in healthcare. I have published a number of papers on that issue. I regularly give presentations to academic and non-academic audiences. Recently I gave a talk to MPs and Peers at the UK House of Lords and I appear in the media giving comments and interviews on conscientious objection. I am funded to lead two separate projects at the moment, looking into different aspects of conscientious objection in healthcare.

I should mention that I am a member of the British Medical Association Medical Ethics Committee. However, I am appearing today in my capacity just as an academic lawyer and not as a representative of the BMA.

The Lord Bishop: Thank you.

Dr Neal, I know that you have studied clause 8 and the conscientious objection provisions in this Bill as they currently stand. So I would like to begin by asking you what your assessment of the conscientious objection package in the Bill is in comparison with the provision that we currently have under legislation.

Dr Neal: There are several things that I would probably like to draw attention to in the conscience clause, but specifically comparing it with the conscience clause in the 1995 Act.

One main difference that is obvious is that the current provision under the 1995 Act requires no discrimination on the grounds of conscientious objection either against existing employees or against potential future employees, against job applicants; clause 8 in the current Bill would remove the protection in relation to job applicants. So that to me represents quite a significant erosion of the protection that is present under the 1995 Act. So it would become lawful, if this Bill were passed in its current form, to discriminate against applicants who would object, or even who *might* object, to participating in providing abortion. That kind of discrimination could foreseeably become routine with the clause as it is currently framed.

The Lord Bishop: Thank you, Dr Neal.

You have highlighted the erosion then of conscientious objection protection under the new Bill in comparison with the existing legislation. That point I believe was highlighted in the House of Keys but was rejected there on two contradictory bases which I would like to ask you now to consider.

In the first instance it was said that it was an unnecessary concern because job applicants with conscientious objections would be protected under the Isle of Man Equality Act 2017. If one leaves aside the inconsistency of suggesting that we do not have the capacity to provide that kind of protection then only to argue against change because that protection already exists, what is your assessment of that argument?

Dr Neal: I do think it is important to acknowledge the contradiction in that position.

First, as you have highlighted, there is a contradiction in saying both that a level of protection can be provided because it would make service delivery impossible, but also that that level of protection already exists. So that does seem to be a contradiction.

I think there is another contradiction there insofar as anyone is claiming that the Equality Act protects potential job applicants, but yet they are not claiming that it currently protects existing employees. So it seems like a contradiction also to claim that the Equality Act provides the necessary protection to applicants but not to existing employees. So I am not sure why that is.

But on the substantive point of whether the Equality Act does provide an adequate level of protection, for me I think the answer to that would have to be no, because in section 11 of the Equality Act it refers to religion or belief and it also defines 'belief' as religious or philosophical belief, but a belief that abortion is morally wrong because it involves the ending of a human life need not be either religious or philosophical.

So I think it is not clear to me that all those who could have moral objections to abortion would necessarily be covered under the terms of the Equality Act. So my view is that it is necessary to make separate provision for conscientious objection within the terms of the current Bill and to ensure that whoever we want to protect is protected by this Bill without the need to rely on the Equality Act maybe picking up some of the pieces.

The Lord Bishop: Thank you.

Then in the second instance it was said that if the kind of protection offered under the new legislation reflected that of the old, that as a small island we would not have the capacity to provide the greater number of abortions without the freedom to discriminate against job applicants with a conscientious objection to being involved in the provision of abortion.

Given your expertise in the field, what would your response be to that argument?

Dr Neal: Obviously if the Bill passes into law the Department will want to ensure that it is able to provide abortion services where those are needed. But I think it is also very important to be mindful that freedom of conscience is a fundamental freedom of the European Convention on Human Rights, so if it is necessary to interfere with that freedom, which it may be, it will be necessary to keep that interference to the minimum level necessary.

So I think this Bill, in just leaving applicants out of the picture altogether, is too wide. I think the level of discrimination that it seems to allow for is too wide and disproportionate in interference with the fundamental freedom of freedom of conscience.

The Lord Bishop: So how might we address that in legislation? What would your suggestion be?

Dr Neal: I have suggested a wording which I think is on your Order Paper.

The wording that I have suggested would, 'prohibit discrimination against conscientious objectors or possible conscientious objectors when hiring new staff, except' – and I am quoting from the wording that I used – 'insofar as minimally necessary in order to ensure the Department's ability to provide abortion services'.

I think the word 'minimally' is not in the form of words on your Order Paper, but that was included in the wording that I have suggested. So the full text of the amendment that I have recommended is that: 'The Department must not refuse to employ a person on the sole ground that they refuse or might refuse to participate in any treatment or counselling authorised under this Act, except insofar as is minimally necessary in order to ensure the Department's ability to provide abortion services.'

I have proposed that because I think it recognises that the Department will have a legitimate interest in, and a need to ensure that it can deliver services, but to do that in a way that interferes with fundamental freedoms as little as possible. So I think that wording that I have suggested expresses a commitment to the principle of upholding and respecting freedom of conscience, and it

also lays down a practical standard against which the policies and the practices of the Department can be measured when it is hiring new staff.

So I think it lays down a measure that we can hold people to when new staff are being hired. We can look at the hiring process and where a decision is made that does discriminate against someone on grounds of their conscientious objection or their possible conscientious objection we can look at that decision and say, 'Well, was that minimally necessary in order to deliver services or does it go beyond what is minimally necessary? Is it unnecessary discrimination?'

I think that form of words is a useful compromise and it allows the needs of the Department to be pursued, but is also very mindful of the importance of freedom of conscience as a fundamental freedom that should be interfered with to the minimum extent that is necessary.

The Lord Bishop: Thank you, Dr Neal.

Hon. Members may have noticed that is at amendment 23A, I believe, on the concatenated list and I would wish to add the word 'minimally' into that when we come to that at the clauses stage. Thank you.

Dr Neal, do you have any other concerns about how the Bill currently addresses conscientious objection?

Dr Neal: There were two other points that I wanted to make specifically about the conscience clause and then there were two more general points about the Bill which stray off conscience a bit.

In relation to conscience, the first of the two points that I wanted to make was that clause 8 makes numerous references to pharmacists. For me, this is welcome. I think pharmacists are certainly among the professionals who are likely to need protection if the Bill passes into law, but I think despite those explicit references to pharmacists there is still some significant doubt whether pharmacists are actually protected by the conscience clause. That is because the terms of the clause protect professionals against having to 'participate in treatment authorised by this Act' and then 'treatment' is defined in clause 3 as, and again I quote, 'beginning with the administration of a drug in relation to medical abortion'. So if treatment begins with administration it seems to me that prescribing and dispensing, which are the two main activities that a pharmacist would be most likely to be involved in relation to abortion, seem not to be protected, if treatment is what is protected and treatment begins with administration.

So that means, I think, that pharmacists are not currently protected by clause 8 as it currently stands. It also means, incidentally, that general practitioners would not be protected by clause 8 as it stands. Since prescribing and dispensing do involve not insignificant degrees of involvement and responsibility for the outcome I think those are activities that should be protected. So in my view the definition of what is covered by the conscience clause is too narrow at the beginning of the process. I think it should also cover prescribing and dispensing.

At the other end of the treatment process I think the clause is too narrow or too narrowly defined at the other end as well, because clause 3 defines treatment as ending with the expulsion of the products of conception and does not cover the disposal of the products of conception. It seems to me that disposing of the products of conception is something that a conscientious objector would certainly wish to be exempt from and should be exempt from.

Certainly I would draw the attention of Hon. Members to the decision of Lady Hale in the UK Supreme Court and the decision of *Greater Glasgow Health Board against Doogan* in 2014. Obviously that was a case involving the statutory interpretation of a different statute, however in the context of a judgment Lady Hale defined treatment as roughly along the lines that are reflected in the wording of the Bill here, but she went on to say that she also thought the right to conscientiously object should embrace the right to object from having to dispose of the foetal tissue and the products of conception after an abortion is complete.

So I think the definition of treatment in this Bill is too narrow at the beginning because it does not cover prescribing and dispensing, so leaves pharmacists and general practitioners unprotected. And I think it is also too narrow at the end of the process because it should also cover disposal. I think that

is the first point that I would want to make in relation to conscience, specifically into the conscience clause.

A second point that I would want to make specifically in relation to the conscience clause is the creation of a new offence under clause 8. I note, although I am not speaking on behalf of the BMA here, I know the BMA has also given evidence touching on this and they make the point, and I would echo their point, that if a health professional's refusal to act, if their failure to act – because we are talking about situations here in which they are not protected by the conscience clause – if somebody who is not exercising a statutory right to object nevertheless fails to act and that failure results in the death or the serious injury of the woman then there are already existing professional sanctions for someone who does that, and if their behaviour was sufficiently egregious there would also be criminal sanctions or there could be criminal sanctions.

So I think, as the BMA has pointed out, sanctions already exist to cover this kind of situation. So there is just no need that I can see for a new offence here. The UK Abortion Act, as Hon. Members will be aware, also rules out conscientious objection in emergencies and yet that statute does not see the need to back that up with a threat of this kind.

So I think the bottom line here and the point that I would want to make is that the purpose of a conscience right is to protect and reassure professionals, not to threaten them unnecessarily – and I think this is unnecessary. I think this drafting sends out the wrong message about conscientious objection as a practice and the unnecessary association with criminality I think is liable to contribute to the marginalisation of conscientious objectors, which is an issue. I think professionals who have a conscientious objection often find it quite awkward to express those objections professionally and I think that having legislative language of this kind in clause 8 associating conscientious objection with criminality is not helpful in terms of embracing conscientious objectors within the professional community, which there certainly are.

The Lord Bishop: Dr Neal, thank you.

As an academic specialist in medical law and ethics, apart from that clause dealing with conscientious objection, are there any other general points that you would want to raise about the Bill as it is currently drafted?

Dr Neal: Yes, actually two things in particular.

First, I wanted to draw Hon. Members' attention to the proposal to repeal section 3 of the Infanticide and Infant Life Preservation Act 1938. This is a section –

Mr Henderson: Eaghtyrane, could I ask –?

The President: Could you repeat that reference, please?

Mr Henderson: Just repeat it a bit louder?

Dr Neal: Oh, sorry, yes.

I am talking now about the proposal in the Bill to repeal section 3 of the Infanticide and Infant Life Preservation Act of 1938.

The President: Could you draw our attention to where that is in the Bill please?

Dr Neal: Oh, gosh, okay.

Mrs Poole-Wilson: It is clause 29.

The Attorney General: It is page 22.

The President: Page 22.

The Attorney General: Clause 29.

Dr Neal: So that section – section 3 of the 1938 Act – is the section that criminalises child destruction. As Hon. Members will be aware, there is an equivalent provision in the England and Wales Infant Life Preservation Act of 1929, in section 1 of that Act. So Section 1 of the English 1929 Act is equivalent to the Island's section 3 of the 1938 Act, both provisions criminalise child destruction, which is causing the death of a viable foetus.

So in England and Wales, section 1 of the 1929 Act in recent decades has been used exclusively to prosecute men, and it has been men who violently attack women who are in an advanced stage of pregnancy, with the result that the woman loses a viable, wanted foetus. So there have been an alarming number of these cases in recent years and section 1 of the 1929 Act has proven very necessary in dealing with those cases and bringing those men to justice. The cases are pretty horrific in nature and the facts of them are fairly unpleasant.

As Hon. Members are probably also aware those who are campaigning to decriminalise abortion in the UK are not proposing to repeal that section. So they are proposing to repeal sections 58 and 59 of the Offences Against the Person Act but they are not proposing to repeal section 1 of the 1929 Act. That is partly because the time limit that imposes is felt to still command majority opinion within the UK, I think. But I think a significant part of the reason why there is no current proposal to repeal the 1929 Act is its usefulness in prosecuting these violent men for the specific harm of the loss of a wanted, viable foetus.

So obviously without the 1929 Act, men could still be prosecuted for assault, for GBH, for attempted murder in some cases, but they would not be able to be charged with the separate and very serious harm to the woman of losing a wanted pregnancy at an advanced stage. It is not something that can be punished adequately under any other legal rule. So my concern is that there is a proposal to repeal the equivalent provision in the Isle of Man when there is, for good reason, no proposal to repeal the equivalent provision in the UK. So I am not sure why this Bill seeks to remove the crime of child destruction from your statute books when those seeking to reform the law elsewhere seem to recognise the necessity of keeping that in place.

So that is the first issue; other issues are in conscience that I wanted to raise. The other and the final thing that I wanted to raise was the wording in clause 12(a) of the Bill – this is the clause that deals with the duties of health professionals in the event that a child is born alive following an attempted abortion. Clause 12(a) reads:

> … if the child is born alive, the medical practitioner, midwife or nurse attending the woman is under a duty, after discussion with the woman, to take all reasonable steps to preserve the life of the child;

So here I think the phrase 'after discussion with the woman' is potentially problematic. Obviously if a child is born alive following an unsuccessful abortion attempt, there are a variety of possible outcomes. In some cases it will be possible to save the life of the child but in other cases it would not be in the child's best interests, possibly to try and save its life – it would depend on the condition of the child when it is born. So I think in some cases it will be appropriate to discuss with the woman.

It also depends on the state of mind of the woman, so the frame of mind of a woman who has gone seeking an abortion and has just been delivered of a live child; I would be very concerned about a woman in those circumstances. My concern about this wording is that it seems to impose a duty in *all* circumstances on medical professionals to try to engage the woman in discussion before making any attempt to try and save the life of a child. I feel that is problematic *both* from the woman's point of view and possibly from the child's point of view, because as soon as you have a born child in existence, someone with Article 2: Right to Life under the European Convention on Human Rights – the most appropriate thing to do may be to immediately start engaging in efforts to save the life of that person.

So I think it is problematic from that point of view, but also from the point of view of the woman to be engaged in discussion or attempts being made to engage her in discussion, when you may be extremely distressed. I am not sure that would always be appropriate. I think it will sometimes be appropriate to attempt to discuss this with the woman before turning your attention to the child, but not in all cases. So I would think it might be more appropriate to leave that wording out of this clause and deal with that in guidance to doctors, where it can be narrated much more fully and elaborated in much more detail when it would be appropriate to do that and when it might not be; and also what their obligations to the child under Article 2 and so on.

So I think the presence of that wording in the clause is problematic for me on both of those strings. I think it would be better to leave that to guidance.

The Lord Bishop: Thank you, Dr Neal, for your expertise on conscientious objection and also for those insights into respectively, clause 29 and clause 12(a). Thank you very much.

Mr President, that concludes my questions for Dr Neal.

The President: Does another Hon. Member – ? (**Mr Henderson:** Yes.)

Mr Henderson.

Mr Henderson: Eaghtyrane, I would just like to thank Dr Neal for presenting to the Bar this morning.

Just one question, really: are you representing any particular professional body here this morning, or are you here in your own personal capacity?

Dr Neal: Yes, absolutely the latter. I am a member of the British Medical Association's Medical Ethics Committee, but as I have said I do not represent them here today.

Mr Henderson: Right, so you are here, presumably under invite from the Bishop?

Dr Neal: Yes, the Bishop invited me as an academic expert in the field.

Mr Henderson: Thank you very much.

The President: Yes, Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President.

I would like then to ask you exactly the same question that I asked Prof. John Wyatt: your personal beliefs, if you would, in terms of abortion?

Dr Neal: So I think that question – and I will answer your question – I think it was certainly a valid question in relation to Prof. Wyatt, because he had mentioned the impact that personal beliefs can have on empirical evidence. But nevertheless I am happy to answer.

What I would do is divide that in two if I can, because I see abortion and conscientious objection as very separate issues. So I will tell you, my beliefs as far as abortions are concerned – and I am not talking here about personal beliefs because those fluctuate, to be honest; but I would say that my beliefs where abortion is concerned are quite nuanced. So I do think abortion is one single issue. I think abortion is a varied landscape. I think abortion is sometimes morally permissible and in other cases I think I would have reservations about the morality of abortion.

I think the healthcare status of abortion also varies, so there are some abortions that I would regard as very clearly treatment and healthcare, and other examples of abortion where I think the status as treatment or healthcare is slightly more – 'problematic' is too strong a word, but it is slightly more contested or contestable. So that is my position as far as abortion is concerned. I think

that there is a varied landscape of abortion and my view about the morality of abortion would vary across that landscape; as would my view about whether or not it is healthcare or treatment.

Coming to conscientious objection, I think I strongly support professionals' rights to exercise conscientious objection. I think that is a perfectly legitimate part of medical practice actually, so I do not think conscientious objectors are people who are opting out of their duties as professionals. I think they are people who are taking a stance within the context of their professionalism. That is my view.

I do think it has to operate within certain strict limits. Different people suggest different limits and my view of the limits is that it should be confined to a narrow range of practices, but within that narrow range I support it strongly.

Miss August-Hanson: Thank you.
Thank you, Mr President.

The President: Thank you.
Mrs Sharpe.

Mrs Sharpe: Thank you, Dr Neal.

I would just like to address the comments you had to make about your suggested amendment about conscientious objection. I do not quite understand how this would work in real life. I understand what you are saying, but do you think you could give a practical example of how a person who has a conscientious objection to carrying out termination can simultaneously ensure the Department's ability to provide abortion services?

Dr Neal: Well, obviously, they cannot; so somebody who has a conscientious objection to carrying out a termination would not be involved in abortion. So my proposal is not that they *should* be; my proposal is that it should be possible for the Department in certain circumstances, insofar as is minimally necessary to deliver their services, to appoint people who *are* willing to carry out terminations.

So I suppose what I am suggesting is that there should be a policy of not discriminating unless there are circumstances in which we can identify a necessity to discriminate in order to carry out, or to ensure the provision of, services. So what I am arguing for I suppose is that the Department should have a limited free pass to discriminate in order to ensure that there are people in post who can provide and deliver abortion as necessary; but the general policy when hiring new staff should be not to discriminate – but exceptions can and should be made if it is necessary to do so. So that is what the language of 'minimally necessary' is supposed to convey.

Mrs Sharpe: I mean, it is a difficult situation especially in a small Island with a limited number of staff, but if the Department was to set up a dedicated service it would be difficult to employ staff who were not willing to carry out terminations.

Dr Neal: At all, do you mean?

Mrs Sharpe: Yes, it would be difficult. I am just imagining a Department which is going to, once this Bill is passed – if it is passed; I hope it is passed – with only a limited number of staff, that if they do have staff, who do have a conscientious objection towards termination, it will be very difficult for those people to work in that unit.

Dr Neal: I think I would say two things. First, it is a difficult balance to strike, you are talking about two sets of vital interests and I think you have to be mindful of both of them. So when you are trying to balance the interests of the Department and providing a service against the interest of individuals to enjoy and exercise their fundamental freedoms under human rights law, yes, that is difficult. But I

would say that both of these interests are vital and need to be seen as vital, and that delivering a service by expecting people to violate their consciences or to not take up jobs that they are otherwise perfectly skilled and qualified to take up, would not be a satisfactory solution as far as I was concerned.

I think another thing to say is just that it is precisely because that is a difficult balance and the temptation would be so strong not to appoint people, if there is any suggestion that they may be conscientious objectors, that is precisely why we need protections. We need protections precisely when people are at risk of being discriminated against.

There is no risk of discriminating against people when it is not in our interests to do that. So because you have identified an interest in discriminating against people, that is why we need to protect people against discrimination, up to a point. So I think a compromise is necessary. It is always going to be a difficult compromise but I think by focusing on the concept of it being minimally necessary, I think that keeps discrimination as the rule; and non-discrimination as the rule when I think non-discrimination should be the rule in any liberal society – but it makes exceptions for cases where it is needed in order to deliver services.

Mrs Sharpe: So you are saying that for example if a woman's life was threatened – ?

Dr Neal: Well, nobody would have a –

Mrs Sharpe: – was under threat, you imagine that someone with a conscientious objection would therefore participate in the termination?

Dr Neal: Well, I think they would have to under the terms of the Bill. I do not think this Bill allows for people to opt out of providing life-saving treatment as is the case in the UK. So even someone who was a conscientious objector in other circumstances would be expected, and rightly so, to participate in a procedure like that.

Mrs Sharpe: Thank you.

The President: Subsection (4) of clause 8 deals with that precise point.

Mrs Sharpe: Yes.

The President: Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President.

Can I ask what study you have done of the current provision by the Department of Health and Social Care here on the Isle of Man that determines your suggested amendment and your argument?

Dr Neal: I have not conducted any studies personally; I am suggesting the wording on the basis of the wording in the 1995 Act and the fact the House of Keys I think considered something quite similar to that and rejected it because it was felt that it would obstruct the delivery of services too much. So the basis on which I am suggesting this is that it is a compromise between obstructing services too much and interfering too much with fundamental freedoms that people are entitled to under the convention.

Miss August-Hanson: Having done no study of the Department of Health and Social Care, I mean, is it possible to determine that?

Dr Neal: Well, I mean, what study –

Miss August-Hanson: As a researcher.

Dr Neal: Well, I am not an empirical researcher of that kind; I am an ethicist and a lawyer.

So one of the questions that I had was, what studies had been done to ascertain the level of objection that was likely to exist among current staff? Have professionals been canvassed and asked would they be willing to participate in abortions? Would they be willing to provide services and under what circumstances? So I agree with you that kind of empirical study should underpin what is being proposed, but I think that when that needs to happen is when the legislation is being drafted and a conscience clause is being considered.

I think it is the kind of due diligence that I would expect drafters to do – not the drafters themselves, but those who are proposing a Bill. I would expect there to be some kind of due diligence in gathering that information and ascertaining levels of conscientious objection. How much of a problem is this going to be for those who are trying to deliver services? And is there a need to discriminate against people or not? I would expect discrimination only to occur in circumstances where it is absolutely necessary in order to deliver the service.

The President: Mr Cretney.

Mr Cretney: Yes, could I ask, is it your view that the Bill, as presently drafted in this context, would place the Isle of Man in breach of the EU Human Rights Act?

Dr Neal: Well, interestingly, there is a case currently before the European Court of Human Rights involving conscientious objection. These cases are rare, so we have a limited jurisprudence on which to draw in order to make those kinds of determinations. I do not know, is the answer. Without court cases I do not know if this would be a breach of the convention. The recent case that we had in the UK which looked at conscientious objection was very narrow and did not consider the human rights dimension of the question, unfortunately. So we have very limited evidence on which to judge whether it is a breach of the convention. But an employment lawyer would probably be better able to tell you about the situation.

Mr Cretney: I was going to ask, but you are aware that before any legislation is finalised, then it is always determined that it is in line –

Dr Neal: Yes, Convention compliant. Yes.

Mr Cretney: Yes.

The President: Mrs Lord-Brennan.

Mrs Lord-Brennan: Dr Neal, thank you.

I was just thinking further about what you were saying, about making sure that for new applicants there is not a risk of discrimination there, and that if anybody has a conscientious objection that is known and they are not discriminated through that process: do you think it would actually be sufficient to be able to deal with that side of things here in terms of what you are proposing in the amendments, perhaps in regulation or policy as an alternative?

Dr Neal: Well, I am not sure.

One of the problems that I think might arise if there is nothing in the Bill, is that because of the terms of the Equality Act at the moment which covers religious and philosophical beliefs, you might end up with a situation where somebody who can show that their objection is religious or philosophical can claim the protection of the Equality Act, whereas someone else whose objection is secular is unprotected. So I would be concerned that as things currently stand, the combination of

this Bill and the Equality Act makes a problematic distinction between religious and secular objections.

I think it is probably not the kind of thing that I would leave to guidance, I think it deals with people's employment rights and I think it should probably be in the Bill.

Mrs Lord-Brennan: Okay.

Mr President, would it actually be okay to ask Mrs Poole-Wilson if she would have any comment on … Or can I not do that at this stage?

The President: No, you cannot, you are addressing the witness at this stage.

Mrs Lord-Brennan: Okay, no that is fine.

Okay, thank you.

The President: I have a question.

You spoke earlier about the employment rights, protection for conscientious objectors in respect of employment by the Department, but after that, if I heard you correctly, I thought I heard you say that the clause, as worded, did not give sufficient protection to general practitioners and pharmacists, who of course are not employed directly by the Department. Did I hear that correctly?

Dr Neal: Yes. I mentioned pharmacists and general practitioners in the course of discussing how treatment is defined in clause 3 of the Bill.

I am not keen to talk too much about employment rates any way because I am not an employment lawyer, I am a medical lawyer and ethicist, but in terms of pharmacists and general practitioners they are not protected from having to … I know that in the UK GPs are protected contractually under the terms of their contract with the NHS, so if there is something similar like that here – it could be that general practitioners are protected contractually but not statutorily. Obviously from my point of view, nothing else is really any substitute for a statutory right, so I would rather see people protected in statute.

However, in relation to pharmacists in the UK, many are employed by the NHS in the UK. So I would be concerned that pharmacists who were being asked to prescribe and/or dispense abortion medication would not be covered by the terms of the clause as it is worded here.

The President: Thank you.

Yes, Mrs Poole-Wilson.

Mrs Poole-Wilson: Thank you, Mr President.

Thank you, Dr Neil. I understand you do not want to get into the debates around the employment rights and so on, but our Equality Act in the Isle of Man has Royal Assent but is not yet fully enforced; but we have Appointed Day Orders when it will come into force and our guidance around meaning is currently being written and developed.

But when I look at the UK's guidance, which I have just looked up on 'belief' and our Equality Act is strongly based on the legislation in England and Wales, the reference here to 'belief' – the example is given: an employee believes strongly in man-made climate change and feels that they have a duty to live their life in a way which limits their impact on the earth to help save it for future generations. This would be classed as a belief and protected under the Equality Act.

So bearing in mind that that has given us a tangible example of what could be classified as a belief and given protection under the Equality Act, I do not know if you have any comment from the perspective of conscientious objection.

Dr Neal: That is interesting because it immediately makes me wonder what about someone who does not believe in man-made climate change; is that protected? Is that a protected belief as well?

Mrs Poole-Wilson: I think it is very open, is the point, so I wondered what your –

Dr Neal: My concern was that the word of the statute in the Equality Act refers to religious or philosophical beliefs and that it is perfectly easy for me to imagine secular objections to abortion which would be neither religious nor philosophical. So if the guidance that is being drafted does provide that kind of protection I would still be concerned about it not being on the face of the Bill.

Guidance is slightly different and I would also still be concerned about why include existing employees in the Bill if we are not including applicants. Why is there a distinction being drawn there? If the Equality Act provides adequate protection for applicants why doesn't it provide adequate protection for those who are already employed?

Mrs Poole-Wilson: I think that was certainly a point that was debated very much by the House of Keys – that issue. I suppose one of the things that I would put to you and just ask for your thought on is what a very different approach was taken in the 1995 Act to the approach that is being taken in this Bill in terms of the extent of the abortion services that we are now looking to legislate around.

So there are a number of people who will be working in the Department of Health and Social Care who were employed at a time with a very restrictive – extremely restrictive – provision around abortion in the Isle of Man, and now we are looking to significantly expand our provision. I wonder what your thoughts are there, that would show a practical reason at least why existing employed people might have continued protection under this Bill, but the issue for applicants could perhaps be picked up?

Dr Neal: The issue then is of people coming to the issue rather than the issue coming to them. So if you are already employed and then the circumstances of your employment are changed radically, as they would be by this, yes, there is a stronger sense of injustice from those people that it has been imposed on them; whereas an applicant is seeking the position knowing what is part of the job.

I see the distinction between the two groups. My concern is that – and the guidance may reassure me in this – if it is just about religious and philosophical beliefs and if that is the basis on which applicants are going to be protected I would be concerned that that is a form of religious privilege and does not adequately protect secular beliefs, unless they can be shown to be philosophical. So I would be interested to see the guidance when it is ready.

Mrs Poole-Wilson: Just one point: I think the wording of the Equality Act is 'religion and belief'. The word 'philosophical' (***Dr Neal:*** No, that is –) does not feature, and that is why the climate change example is given as a form of secular belief.

Dr Neal: It says 'religion or belief' and then 'belief' is defined as 'a religious or philosophical belief'. So the belief part, which is where I would hope that the secular protection would kick in, is then defined itself in terms of religion or philosophy. I just think it is possibly not sufficiently open.

Mrs Poole-Wilson: Thank you.

The President: Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President.

I would like to point out that we do already have conscientious objection; the precedent is already there for those people not to be involved in surgical abortions where performed in the Hospital, or the exceptions to save a life where involvement is mandatory, and that is regardless of any conscientious objection. We do know that some Filipino theatre nurses do not really get involved anymore.

So what is your understanding of how, in an ideal world, it would be expanded upon?

Dr Neal: I am aware of the protection that exists under the 1995 Act and I have already compared that to clause 8 of this Bill. So I am not really sure what the question is. How much conscientious objection I think people should be entitled to exercise?

Miss August-Hanson: Yes, above and beyond what may be put down there.

Dr Neal: I have said that I think treatment, in other words what people are allowed to object to, should be more broadly defined than it is here. I think it should include prescribing and dispensing medicines for abortion and I think it should extend to cover disposal of the products of conception after an abortion. So I would favour a slightly wider opt-out than this provides for.

Miss August-Hanson: And no further than that, in your personal understanding and belief?

Dr Neal: In some circumstances I think I would go further.

It is very complicated because I have a very particular view of conscientious objection in the healthcare context, which is a complex argument that is based on the nature of healthcare and the purposes of treatment and therapeutic benefit. So there are some circumstances, but as I have said already I think that in some cases where abortion is indisputably treatment and therapeutic, I do not think there should be the freedom to opt out at all. In other cases, where I think the status of abortion as treatment is contested, I think there should be quite wide-ranging rights to opt-out.

Those are my very personal and specific academic stances and I am not sure that they are particularly relevant to this Bill.

Miss August-Hanson: I was just trying to understand where you are coming from as an individual.

Dr Neal: Okay.

Miss August-Hanson: Thank you.

The President: Mrs Hendy.

Mrs Hendy: Thank you, Mr President.

Thank you for your submissions today and your evidence, it is very helpful and again thought provoking.

I have got a hypothetical situation to put to you and I wonder if you could explain how the additional subsection that you have tabled today, or might be tabled, would view this.

If, for instance, the Department was seeking to appoint a consultant, given that the clinic that might administer the abortion process would be a very small operation and there were two equal candidates but one had a conscientious objection so that that would make the service non-deliverable, would you then interpret that the Department is able at that point to make a choice between those two candidates because it would mean that the service became inoperable or undeliverable?

Am I understanding your subsection correctly?

Dr Neal: Yes, that is what it would mean as far as I am concerned.

Mrs Hendy: That the Department would be protected?

Dr Neal: Yes. If a service would become undeliverable by appointing one person then there would be an obvious justification for appointing the other person.

Mrs Hendy: Thank you.

The President: Mrs Lord-Brennan.

Mrs Lord-Brennan: Dr Neal, do you have any comment on whether conscientious objection issues might be more of an issue for the delivery of the services for the Hospital and indeed for the people that are involved in the care – might be more of an issue up to the point at which an abortion is carried out, because after that it might be thought that then it is a healthcare issue – the health of the woman? So really what we need to be looking at more is the lead-up to those services, to ensure that both conscientious objectors are protected but at the same time it is possible to access those services all the way up to the point at which an abortion takes place; then after that it is more of a 'healthcare of the woman' issue?

Dr Neal: Once the abortion has taken place I do not think there is any scope really other than, as I have said, and as Lady Hale said in her judgment, I think it is appropriate to cover the disposal of the foetal remains or the products of conception after the abortion, because I think to expect a conscientious objector to be involved in that would be –

Mrs Lord-Brennan: I mean aside from that –

Dr Neal: Aside from that I think –

Mrs Lord-Brennan: – the general healthcare of the woman –

Dr Neal: I do not think there is any right to conscientiously object to providing patient care. (**Mrs Lord-Brennan:** Yes.) So things like monitoring somebody's blood pressure, giving somebody antibiotics, things like feeding and toileting if that is necessary. So I do not think you can have a conscientious right not to care for someone.

Mrs Lord-Brennan: Do you think we need to make provision to make sure that that element of care can still happen without somebody deciding to effectively opt-out of anything to do – ?

Dr Neal: No, I do not think the Bill gives people the right to opt out of anything to do with the patient. (**Mrs Lord-Brennan:** Okay.) I think it is important and I would like to just emphasise that a conscientious objection, as I understand it and as most academics who write about it understand it, is an objection to a practice and not a patient. The minute it becomes an objection to a patient it is no longer conscientious.

So I think the Bill does not raise the risk of a free-for-all in terms of conscientious objection or opting out. I think it is quite narrow. I think it is a little bit too narrow at either end of the treatment process, but I certainly do not think that you need to put anything else in place to ensure that people would not be allowed to opt out any more widely. I do not think they can.

Mrs Lord-Brennan: Okay.

The President: Are there any further questions of this witness?

Dr Neal, on behalf of Council I would like to thank you very much for giving evidence to us this morning. It has been very helpful indeed. Thank you very much.

Dr Neal: Thank you.

The President: Hon. Members, Council will now stand adjourned and we shall recommence at 2.30 p.m.

The Council adjourned at 1.03 p.m.
and resumed at 2.30 p.m.

Abortion Reform Bill 2018 –
Second Reading approved –
Clauses deferred until next meeting

The President: Fastyr mie, Hon. Members.

Members: Fastyr mie, Mr President.

The President: Fastyr mie, Hon. Members.

Members: Fastyr mie, Mr President.

The President: Please be seated.
We resume our Second Reading debate on the Abortion Reform Bill and I call on the Lord Bishop.

The Lord Bishop: Thank you, Mr President.
Before lunch we heard from Prof. Wyatt and then from Dr Neal, and perhaps I might just take this moment to reassure Hon. Members around the concern that the hon. mover Mr Henderson raised a couple of times. Just to say that everyone whom I have invited to appear does so as an individual and not as a representative of any organisation, and therefore also probably their own individual personal context is of lesser importance.
What I have sought to do in wanting to challenge us to reflect more widely around these issues was to address those three particular areas which for me remained significant: firstly, the question of the status and nature of the foetus, and that was addressed for us by Prof. Wyatt; secondly, questions around conscientious objection and law, which were addressed by Dr Neal. The third area in which I had a concern has to do with our own healthcare workers on the Island and particularly the question now of the responsibility that is placed upon pharmacists to prescribe as well as to supply abortifacient pills and the associated issues of safety, training and advice.
Mr President, to assist us with the question of this aspect of the role of pharmacists and other healthcare professionals I would like Council to have the opportunity to hear from Mrs Maire Stapleton, who is sitting in the public gallery.

The President: Indeed. The microphone, please.

Mrs Stapleton: Thank you, Lord Bishop and President.

The President: Good afternoon, Mrs Stapleton, and welcome to the sitting. If for the record, please, you could state your name, position and qualifications.

Mrs Stapleton: My name is Maire Stapleton. My position at the moment is Formulary Manager for the Buckinghamshire Joint Formulary, which is a formulary that covers prescribing for all hospital specialists, all hospital doctors and all primary care prescribers in the county of Buckinghamshire.
I have had this role for 14 years and a central part of it is to do with looking at new medicines or new guidance and introducing it to be used within the county to look at the safe-as-possible practices, to harness national and professional guidance including NICE, and to seek to address all aspects of introduction of a new service and a new medicine. They are very often very closely interlinked and intertwined.

I am from the Isle of Man. I have worked as a pharmacist for more than 40 years, partly overseas with the World Health Organisation and UNICEF, and latterly in the last 20 years in the National Health Service. I have been very happy to be able to apply my experience in a small way to looking at the Isle of Man revision to the Abortion Act.

The President: Thank you very much.

Lord Bishop.

The Lord Bishop: Thank you very much, Mrs Stapleton, for giving us that summary of your experience and expertise.

Our Bill as presently drafted will authorise the prescription of abortion pills by approved pharmacists up to 14 weeks' gestation. Would you be able to comment for us on the appropriateness of pharmacists taking on that role independently up to that point of 14 weeks' gestation?

Mrs Stapleton: Thank you, Bishop.

I would just like to step slightly backwards for a second, if I may, to just look at the medicines that we are dealing with, because that will help us to answer some of the wider questions.

The medicines used for termination of pregnancy are mifepristone, which is administered initially, and then 48 hours later misoprostol, which helps expulsion of the foetus. I have looked fairly carefully at the product licences of these medicines to see what is seen legally to be safe practice for the use of these medicines. I am fully aware that these things have probably been extremely rigorously discussed previously; I just want to point out two or three things about the medicines.

One is that in the summary of product characteristics for mifepristone, which is the thing that stimulates the abortion in the first place, it makes it very clear that the risks of failure are not negligible and they are between 3% and 7.5%. That is side effect number one. The second one is that the risk of heavy bleeding is around 1.5%. And the final risk is infection post abortion leading to pelvic inflammatory disease, or endometritis, which is up to 5%. So we just need to bear these three things in mind.

There certainly are other risks as well, but whatever a professional does, they have to work within the guidance of the product licence or have very good justification to move away from it. That would be what the General Medical Council (GMC) would require of anybody prescribing the medicine.

In relation to pharmacists, until I think two or three years ago pharmacists could not prescribe in the UK, but guidance and regulation for independent prescribing, which requires a pharmacist, or indeed other non-medical practitioners, including nurses and midwives … To be able to prescribe, they have to do an extra six months' training. So it is a fairly new role for pharmacists; it is a new role for nurses and midwives. It is certainly increasing, but it is still pretty new. In the last five years it is starting to grow, and indeed newly qualified pharmacists when they come to work with us are very keen to be funded to do this extra training because it widens up the area of work that they can do.

So in relation to pharmacists – and nurses and midwives, because I am afraid I do have to include all three because they are in some ways … I apologise if my response is slightly wider than the original question. The answer applies to all three, in that they can only prescribe if they can demonstrate adequate competency, and that would be for any medicine for any disease.

In the UK, prescribing for termination of pregnancy by non-medical independent prescribers is illegal, so pharmacists, nurses and midwives do not and cannot prescribe these medicines at any stage of gestation. However, if the Isle of Man Act is approved as it stands, they will be allowed to in the Isle of Man. But to ensure that they have an adequate competency, we need to delve a little bit more deeply.

It is obviously a personal professional responsibility to make sure that you have that competency. The Royal Pharmaceutical Society's view is that it is not planning to publish any guidance to support

pharmacies to do this prescribing, nor does it have a plan to write to the Royal College of Obstetricians and Gynaecologists to take advice on what that competency looks like. However, in accordance with the regulation on non-medical independent prescribing, the Royal Pharmaceutical Society supports pharmacists with independent prescribing qualifications doing this.

With nurses and midwives it will be the same thing, except that at least there is some guidance from the Royal College of Nursing on independent prescribing published in July 2017, albeit it did draw attention to prescribing for termination of pregnancy is not allowed for nurses and midwives. But there is wider professional guidance recently published in the context of this for this area of clinical practice for nurses.

Trying to drill down further into this is slightly ... What can I say? It is a very new territory. A view from the Royal College of Obstetricians and Gynaecologists has not been given on what would be deemed adequate competency for a pharmacist to prescribe. Having looked more carefully at the … There are advanced training modules for trainee obstetrician gynaecologists, showing the curriculum and all the competencies that they expect for a trainee consultant. That was published by the Royal College of Obstetricians and Gynaecologists about three years ago. It is pretty rigorous and I suspect if I was a pharmacist wanting to be a prescriber in the Isle of Man I would be going straight there and trying to find out how I can gain those competencies in the UK initially before coming back here.

I have spoken to the British Pregnancy Advisory Service. In fact, I have spoken to the pharmacist who advises that service, Ross Lynton-Groves, who has informed me that only a handful of pharmacists in the UK have the competency, have the experience for work within abortion services and could prescribe, should it have been legal in the UK. So we are dealing with a very new area, which is not impossible but it is certainly brand new.

If you look at the competency framework produced by the Royal Pharmaceutical Society for all prescribers – doctors, nurses, midwives, everybody – it makes it clear that, as far as possible, prescribing should be as multi-disciplinary as possible, defining roles and responsibilities across different professions, working as a team. Competencies should be used in guidance to support the prescriber, and certainly that is a big hole here for pharmacists right now, but it is not impossible.

So, trying to answer the question in a more focused way, I would say – and this is an individual view – the wisest thing for a pharmacist to prescribe and gain competencies would be to directly communicate with the Royal College of Obstetricians and Gynaecologists and find out in more depth what is needed. I cannot answer the question about how long it would take, in what capacity etc. I think these are questions that need to be taken further.

The Lord Bishop: Thank you very much indeed, Mrs Stapleton.

What you have done there, I think, for us is to establish that link between pharmacists, nurses and midwives, to note some of the risks associated with the medicines and, most of all, to identify that we are moving into very new territory and there is a significant lacuna, a significant gap, in experience, in training and in competency that would need to be made up, and that guidance on that is not immediately forthcoming – nothing yet from the Royal College of Obstetricians and Gynaecologists – and clearly a personal and professional responsibility upon pharmacists, nurses and midwives to make contact with those supervising organisations in those ways to find out what support they will be given in going into that new and uncharted territory.

In the light of that, I think I would like to ask you about what safety issues you might see for women in the Bill as presently drafted with pharmacists allowed to prescribe abortion pills.

Mrs Stapleton: I think I would like to just firstly make everybody very aware of what the term 'independent prescriber' is. It does not mean that a pharmacist acting as an independent prescriber works in isolation from the rest of the healthcare team. It just means that the pharmacist – or the nurse or the midwife – is accountable and responsible for his or her own decisions. It does not mean they work in isolation.

I think this is an extremely important point because if you look at the Royal College of Obstetricians and Gynaecologists' guidance on abortion services, which is seen as very much the

basis of service specifications for commissioning abortion services across the UK at the moment, it is absolutely mandatory that there is a multiple-disciplinary team, that there is very close working between professional services. There is no independence between one professional and another and I think that needs to somehow come out in the Act because I think it could be misconstrued that a pharmacist, nurse or midwife could set up a service in isolation, which certainly would not allow them to demonstrate or assure themselves of competency nor provide a safe service. I can give you some examples of what …

The other aspect is the product licence in terms of the safety issues. So, for example, with the licence for mifepristone it states that there should be … Well, it is basically illegal, or it would be against the law for mifepristone to be prescribed if the pregnancy was not confirmed by an ultrasound or biologic testing. So you would have to have that in place. You would need access to surgical removal because if there is a fairly substantial risk of failure of the drug you need to have access to potential surgical removals. Again, you need to be part of the wider healthcare team, not working in isolation. In the summary of product characteristics, which is the product licence for the combo pack, which is the combination of mifepristone and misoprostol, it talks about excluding and having somebody do … I am sorry to make this point, but of genital mutilation and confirming that there are no abnormalities which would prevent expulsion. There is the importance of sexually transmitted infections assessment. There is the need for resuscitation facilities, for emergency blood transfusion facilities and it also really emphasises – this is the product licence that I am talking about, not the Royal College guidance – the importance of good medical facilities.

I think independent prescribers, like all prescribers, have got to be very aware of the requirements of the licence of the product they are prescribing, and if they deviate from that – which is common in paediatrics, for example; if you have good reason to deviate from it you need to really have risk-benefit assessment of that and that needs to be able to stand up to protect you, so if there was any kind of litigation against you it would be defensible.

So from the prescriber's point of view they need to be safeguarded in terms of how they work within the licence and how they work within competency frameworks which may or may not exist at the moment.

The Lord Bishop: Thank you very much.

If we wanted to look at an amendment to the Bill that would make the process legally safe for women, what might that look like? What advice could you give us, do you think?

Mrs Stapleton: I think, just going back to the product licences and also the practice of the British Pregnancy Advisory Service, it appears that 14 weeks for making that first preliminary hurdle and decision-making about termination seems to be outwith what the licence states and also what the British Pregnancy Advisory Service do. They generally have that review at nine weeks. They observe the patient during the administration of misoprostol. They keep the patient under observation for three hours, which again is in the licence. They follow up after seven to 14 days, again in the licence. They keep patients in if there is any suspicion.

So I think the wording at the moment perhaps needs a little more drilling down and I think probably consideration about bringing 14 weeks down at least to what the licence states, which is 63 days of amenorrhea, which is about 11 weeks, or to align with what the British Pregnancy Advisory Services are doing, which is the most widely used service in the UK, which would be nine weeks. So 14 weeks is certainly outwith what the licences are stating, and when you are dealing with independent prescribers, I am not saying that they are willing to take less risk than medical practitioners but they are definitely going to be in a new area of practice which has not gone before.

The Lord Bishop: Thank you.

I would like, if I may, to ask you a question that relates to the conscientious objection principles that we were speaking about earlier on. At present the Bill allows conscientious objectors to withdraw from involvement in treatment, which is defined as starting with the administration of

abortion medication or the start of a surgical procedure and ends with the expulsion of the products of conception. What issues in the Bill, if any, do you see with regard to pharmacists who have conscientious objection prescribing or supplying abortion medication?

Mrs Stapleton: Okay, well, the General Pharmaceutical Council guidance on conscientious objection is quite clear that any pharmacist for any medicine for any disease state, if they have a conscientious objection, needs to speak to their employer, their colleagues, and it will not be held against them in any way from an employment point of view if they choose to excuse themselves from undertaking that particular work.

I would not like to see the Act here takes that professional guidance away. I would want it to absolutely support that because I would suspect that it would be very difficult for pharmacists to work outside the professional guidance and I know that the statutory position would trump that in any court of law. But I would totally agree with what Dr Neal said earlier – that we have to be really careful not to … I can see there is a balance to be made and the delivery of the service certainly is essential, but you also want to recruit pharmacists to work here. You do not want them running away. You want a gold-standard service. If you are going to lead the way, you want it to be good and I think, at the moment, not reflecting the General Pharmaceutical Council requirements is a concern.

The Lord Bishop: Would you advise any amendment upon us that would enable pharmacists with such objections to practise which would not compromise the availability of relevant products?

Mrs Stapleton: I think I would go with what Dr Neal said earlier, which I think was a reasonable form of words.

The Lord Bishop: Thank you.

And finally from me, I think that the Bill proposes to the pharmacist, if a pharmacist has a conscientious objection, then if they fail to give the woman sufficient information to enable her to exercise the right to see another relevant professional pharmacist there is a possible 12-month prison sentence. Would you have any comment on that, or on how that is perceived by pharmacists?

Mrs Stapleton: I think that would be very unpopular. I think again I would revert back to what Dr Neal said, that we have really got to work within professional guidance and not try and deviate from it. I think that would be extremely unfair and – this is my personal view – I suspect it will make it very hard for pharmacists to get involved in this at all. I think it seems excessively punitive.

The Lord Bishop: Thank you, Mrs Stapleton. Those are all the questions that I had. You have answered them all.

Thank you very much, Mr President; that is it from me. Thank you.

The President: I wonder if I may start with a question, actually, in relation to clause 11 of the Bill, 'Provision of medicinal products to procure abortion', in subsection (2)? You referred to this earlier in your presentation.

It says that:

> During the first 14 weeks of the gestation period, a registered medical practitioner, midwife, nurse or pharmacist may —
> (a) prescribe a relevant product for a pregnant woman, or
> (b) supply a relevant product to a pregnant woman.

First of all, the relevant product in question is invariably going to be licensed as a prescription-only medicine – that is correct. Therefore when it says that a pharmacist *may* supply, that is simply an enabling power in law that allows the supply under the product licence conditions. So in other words the pharmacist is enabled to supply but will only do so if there is a prescription against which

to supply it, from a medical practitioner. So there is no question of any supply being made other than against a prescription. You would agree with that?

Mrs Stapleton: Yes, I would.

The President: As far as Part A is concerned, would you agree – and this was the bit where you made reference to professional competency. Again, we will include the pharmacist in the category of 'independent prescriber, midwife, nurse or pharmacist'. What the law is saying is that they *may*, they are enabled, to prescribe a relevant product for a pregnant woman, but in practice would only do so if they were professionally competent and there was a competency framework in which to operate. So even though the law says that they may do so and they are enabled to do so, professionally and ethically they would not do so as an independent prescriber, until they were satisfied under their professional practice that they were competent to do so.

Mrs Stapleton: That is correct.

The President: That is correct. So the law is simply making an enabling provision which, if it ever happens in the Isle of Man – bearing in mind that the General Pharmaceutical Council or the Royal Pharmaceutical Society have not got professional guidance in place for such situations – even though the law says you *can*, it would not happen until the independent prescriber had gone through the proper competency training, (***Mrs Stapleton:*** Yes.) under guidelines and so on? (***Mrs Stapleton:*** Correct.)

That is fine, thank you for clarifying that.

Now, are there any other questions? Yes, Mrs Poole-Wilson.

Mrs Poole-Wilson: Thank you, Mr President.

And thank you very much for your evidence so far.

Actually, just carrying on from the points that the President has been making, another clause of the Bill, clause 5, provides where all abortion services under the Bill may be provided. It states that:

> Abortion services may be provided … only –
> (a) under the Isle of Man National Health and Care Service … ; and
> (b) in a national health service hospital or in other premises approved for the purpose by the Department.

– in this case the Department of Health and Social Care. It goes on to state:

> An approval under subsection (1)(b)

– which is any other premises,

> … may contain such conditions and exceptions as the Department thinks fit.

And finally in relation to the section we have just been looking at, which is the enabling power, the future-proofing of the Bill to enable in due course perhaps independent prescribers to prescribe as well as supply, it makes clear that abortion services may be provided under that section:

> … in such manner, by such persons and in such places as may be approved by the Department.

I wonder whether, bearing in mind that, that also provides very clearly a clear power for the Department to specify some of the safeguards that you have been talking about – team-working, the availability of access to surgical support if required. So I wonder whether you can see that there is power in the Bill, as it stands, to provide for these safeguards?

Mrs Stapleton: I can see there is power in the Bill but I am also aware that it is … if in doubt put a little bit more meat to it within the Bill, because guidance has far less power than the actual Bill itself. And given that we have talked about individual professionals, we have not mentioned the team.

My instinct would be to have some clause – I am not sure where it would sit – but to allow and draw attention to the importance of working within the recommendations of … You cannot talk about UK professional guidance can you? Or national professional bodies? Could you do that?

Mrs Poole-Wilson: Well, the language in the relevant section of the Bill talks about services being provided 'in such manner'. So the Department's legal approval of the provision of these services, the Department could specify very clearly, and the manner might conceivably involve which guidelines are relevant and other elements that must be adhered to in order to provide the services. So I suppose what we are dealing with here is a piece of primary legislation which is designed to enable the provision of services, (***Mrs Stapleton:*** Yes.) not just today but for the long term.

And it is interesting, we have talked about the relevant products that are relevant today. I suppose none of us know what future products may become relevant and licensed in this area of healthcare. So the Bill also has to be written in a way to enable not only the type of product that is available today but that *may* become available; but also the ways in which, and the individuals who may be authorised in due course, appropriately, to provide those services.

So I suppose you could write a lot of detail but you would only write what you could write in today's knowledge, and a piece of primary legislation like this in a way is enabling detail to be built upon to reflect ongoing change and practice and appropriate guidance.

Mrs Stapleton: Would it be possible, sorry, to have principles rather than detail? So, for example, to take into account the guidance from professional bodies and the product licences? That would future-proof you, but it would not mean frequent update.

They are the two things that really drive what a professional can do and demonstrate competency to themselves and to others.

Mrs Poole-Wilson: But I suppose I wondered whether the wording that is drawn very widely saying that the Department of Health will only approve 'in such manner', that language is very open and it allows exactly what you are talking about, it allows the Department to say in approving provision of services under section 11, which is the prescribing and supply of relevant products, regard must be had to perhaps professional guidance or other things – I would not be the expert there. But I wondered if knowing that that is there … ?

Mrs Stapleton: Yes, those three words 'in such manner' … I am not a legal expert, I am a pharmacist who reads guidance and I do not know whether you have provision for an extra sentence in there to say 'for example' – so that you are not restricting yourself – the product licence and professional guidance; because they will never go away but you may want to add other things in due course.

Mrs Poole-Wilson: Yes, and I think I understand that, and I also think that the point the President made which is in reality a professional would not act outside a product licence because they are supposed to prescribe in accordance with the product licence, and the power would be there for the Department to make certain specifications that would enable the provision of these services in practice to be done in the most appropriate way.

Thank you.

The President: Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President.

And thank you for the evidence that you have provided, I appreciate it.

I would just like to add to that, in front of me I have a letter from Ash Soni, who is the President of the Royal Pharmaceutical Society, in relation to this Bill. What he says is that, quote: 'We believe in equality of access to safe and effective medicines, treatment and support initiatives which improve patient access to the care that they require. Many pharmacists are now independent prescribers and are playing an increasing role in delivering health services across Britain. As you may be aware independent pharmacist prescribers can prescribe, within their competencies, in any therapeutic area. Pharmacists will always make the care of the person their priority and should handle requests sensitively in line with regulatory guidance. Pharmacist prescribers should therefore not be excluded from prescribing by any new legislation'.

Can I ask what your view is therefore about the use of metapristone in surgical termination?

Mrs Stapleton: That is within the licence of the product, so that is fine. (**Miss August-Hanson:** Okay.) It is within the product licence.

Miss August-Hanson: In terms of the prescription, then … Your past experience, you say, was in Buckinghamshire?

Mrs Stapleton: And current, yes.

Miss August-Hanson: And current. Have you spoken to any pharmacists on the Isle of Man about this particular Bill; and what has been their reaction to it in terms of prescribing?

Mrs Stapleton: Yes, I have written two letters to the House of Keys since the beginning of the year and I copied in … I have forgotten her actual title; I think she is chief pharmacist within the Department of Health here, Maria. I asked if she could … I would be very happy to talk to her about it. I have not received a response. And I have spoken to another colleague of mine, who studied at school with me here, and discussed that with her.

That is all I have managed to do. I live off the Island. I try to engage and I have just invited comments from two other pharmacists.

Miss August-Hanson: Right, okay.

Sorry, Bishop, I know that you said that you think that because they are independent witnesses they do not necessarily have to outline their belief system. I would say quite the opposite, that because they are not part of an organisation it would be more relevant, and perhaps it would be interesting to hear what their belief system is in terms of being in this Chamber and giving evidence in this Chamber.

So, can I ask what your belief system is, please, if you would not mind answering the question?

Mrs Stapleton: Yes, I would just like to say if I was sitting in the Buckinghamshire Formulary Management Group and presented the information I had found following a full literature search, contacting and reviewing guidance, I would not be asked for my personal view at all.

The view I have given today is entirely based on professional guidance and views from the Royal Colleges, so I personally feel it is quite irrelevant and I am slightly concerned that that question keeps being asked because I do not think it is professionally appropriate, quite frankly. I have come here as a professional pharmacist and I am not here in any other capacity.

Miss August-Hanson: Forgive me, but the reason why I ask the question is because it is important for the Council to understand who the witnesses are that are giving evidence as individuals in this Chamber. So I am interested to hear that, but if you are not willing to give that, that is fine. Thank you. I appreciate that and I respect it.

Thank you, Mr President.

The President: Thank you.

That is a perfectly appropriate answer that you gave, I must say.

Mrs Lord-Brennan.

Mrs Lord-Brennan: Mrs Stapleton, thank you so much.

I understand a little bit where you are coming from because I have struggled with what is almost a peculiarity of what we are doing here compared with Ireland, for example. What we are getting into now – and I think we will be drawn into this again – is the whys and the hows of how this will become a system and a service that is workable and in place. And it is almost impossible, I think really, to look at this legislation without thinking of the impact, because what we have is a Private Member's Bill that actually, as I think you would have picked up and I have picked up from my own enquiries as well, it has not had Health Department input yet and I certainly have the expectation, and I think lots of other people will, that once it is passed through the Branches, which I hope it will be, then we will be looking for so much to come from the Department that will fill in the blanks and make sure the how it is going work is going to play out. What we are doing here is the framework and it is the parameters.

So what I wanted to ask is … some things that you have mentioned there, and I think it is really important about – you talked about the whole healthcare team, the whole service, you can talked about the services across primary care, the professional guidance you have mentioned from the Royal College of Gynaecologists, as well as the relevant professional guidance from the Pharmaceutical Society – if those stipulations, requirements, standards of best practice were to come through at a later stage by way of regulation, by way of the Department of Health and Social Care saying, 'This is how we are going to put the whole service together' would that be sufficient from your point of view?

Mrs Stapleton: I think we have just got to make sure we have got checks and balances and teeth. And when things are slightly woolly it is hard to hold them to account. Sorry, I am not meaning to be critical –

Mrs Lord-Brennan: No, not at all.

Mrs Stapleton: But I am always twitchy and nervous, I like things to be drilled down because I see it in my own work the whole time – holding professionals to account, holding ourselves to account does not happen with a general statement. So I personally would still put something in about, 'in due cognisance of professional guidance and the product licence'. I think that is generic enough to be future-proof, but still will hold us to account.

And we have to be mindful, just off up the subject slightly, NICE are publishing their guidance on termination of pregnancy in September next year. (**Mrs Lord-Brennan:** Right.) The UK is holding their breath. The pharmacist who advises the British Pregnancy Advisory Service said, 'We are not going to change anything in the UK, we are going to wait for NICE; we are not going to push for any independent prescribing to change the law in the UK because NICE may or may not give us something to take forward.' So you are probably going to find significant changes quite soon but you will never deviate away from professional guidance, which includes NICE and the licence.

Mrs Lord-Brennan: Okay, that is helpful and I was not aware of the NICE guidance that would be forthcoming next year.

Hypothetically then, do you think as this were to come into operation, and it is obviously not for the Legislative Council to … we cannot really get into the hows and whens of how that is going to come about. But hypothetically a cautious approach would be to keep things within the realms of general practice and doctors as a first step and then further down the line, once you are getting into pharmacists potentially prescribing, the NICE guidelines would be something to take into account – so possibly a phased approach?

Mrs Stapleton: That may be a good idea. I think particularly with pharmacists, because if you have got a handful of people in the UK, pharmacists who have got expertise in termination of pregnancy, the chances of having somebody here are pretty slim, unless they start moving over for that reason. I suppose it is not the end of the world that it is in the Act if it is not being implemented, but yes, a phased approach might be a very sensible way of dealing with it.

I am sorry, but I have still got this question, which I have not answered in my mind but perhaps I can … I should not be asking you questions, you are here to ask me questions, but still I am wondering whether this 14 weeks for making a decision, up to 14 weeks of termination for an independent prescriber, where that has come from, given what I have said earlier that the British Pregnancy Advisory Service go up to nine weeks at that point, and the licence is 63 days of amenorrhea for medical termination of *in utero* foetal growth.

I have not understood where the 14 weeks has come from and knowing what I know, and what I have found out, I am slightly puzzled about it, and whether that will put independent prescribers in a difficult position, because they will be working outside the licence of one of the products, which is the combination product, and it is actually contraindicated in patients who have had amenorrhea more than 63 days. They will be working out of licence, which is still possible, they can do that, but it will require a risk-benefit assessment and a defensible justification. I just want to draw the room's attention to that difference between the licence and the actual number of weeks that a pharmacist, nurse or midwife can prescribe.

Mrs Lord-Brennan: And the combination there that you mentioned, is that the normal medication that would be used?

Mrs Stapleton: It **i**s commonly used, yes, but you can also use mifepristone on its own and use misoprostol separately.

Mrs Lord-Brennan: Okay, thank you very much.

The President: Are there any other questions? No.

In that case, Mrs Stapleton, on behalf of Council thank you very much for your evidence this afternoon, it has been useful and interesting.

Thank you.

Mrs Stapleton: Thank you very much; and thank you, Lord Bishop.

The President: The Lord Bishop.

The Lord Bishop: Thank you, Mr President.

I also thank Mrs Stapleton for her evidence. In her absence I thank Dr Neal and I thank Prof. Wyatt as well; and I thank you, Mr President, and all Hon. Members for giving to me the time today to do this.

I will not add to what I said this morning. I think in what I said this morning I have probably said what I wanted to say, but I hope that I have perhaps achieved my aim of enabling us to enter more fully into this legislation which, in my phrase, I believe we have to understand and inhabit if we are to own it. I hope that I have perhaps challenged us to look at the immensity of responsibility that it carries, the immensity of the issue that we are looking to enact and indeed some of the practical nuances of the outworking of it.

So, again, my thanks to those who have given us their witness, my thanks to hon. colleagues and, Mr President, my thanks to you.

The President: Thank you, Lord Bishop.

Mrs Lord-Brennan.

Mrs Lord-Brennan: Thank you.

I am going to link back to something that was raised this morning, which seems like a long time ago now in some respects, but I wanted to really respond to the Bishop's original contribution about due regard to both lives and the reality of the situation, truths and the danger of the broken relationship and anguish and when a woman is going through a crisis pregnancy, and also perhaps draw back to the account that Mrs Sharpe made, where the woman, the teenager in this instance, said that she would have resented the child, she was not ready to be a parent, and about the issue that it would not have been a wanted baby. I want to just draw back to some of the realities of the situation there.

I think something that I did struggle with initially is obviously you have got quite a long period of time up to 24 weeks for abortion. Because I think, in my almost naivety, before I started looking into this seriously and looking at different accounts about the harsh realities as women try and navigate these difficult issues, because you would like to think that the other alternatives are always better. I think that in focusing on the value of the life of the unborn child, of the foetus and the woman's independence of judgment, I think something that has not really come across is that when a woman is going through a crisis pregnancy she is having a longer-term view and she is thinking about what life is this child going to have. So it is not always as straightforward and simple as, 'Will I have an abortion or not?' And it is not just about the stage of the life, which actually is a potential life.

And so the imagined alternatives, of course, would be that actually even if a woman felt that she did not want a baby, that that child might be adopted or it might be fostered and then everything would be well just because the child had been born and fine, but actually I think that the reason why we need to have this independent and individual judgment is because the woman will think about, 'What will happen if I bring this baby to the world?' And actually in her own judgment it actually might be sadly, and in a difficult way, she might feel that it is a better choice actually to have an abortion rather than to give a child up or to have that child go through a situation or a life where the child is resented or it is unwanted. I think that is an element here that we have not really talked about when we have talked about the life and the potential life and the experience.

I really just wanted to talk about these things because we have talked about truth and reality, and I think actually this is another reality that has not really been talked about here, and it is the woman who has to navigate that tragedy and she would have to resolve herself in that situation.

We are still at the Second Reading so I do not know if there is anybody else that may be around the table that is able to talk a little bit more about the other alternatives that we assume that might be an easier option as opposed to abortion, because sometimes a woman may not have any other options and the options that you would like to see are still very difficult options for the child. So I just do not know whether there is anybody else who would like to add to that really.

The President: Thank you.

Mr Henderson.

Mr Henderson: Gura mie eu, Eaghtyrane.

I would just like to call my expert witness, if I may, to the Legislative Bar, which is Dr Allinson; and I would ask if the mike can be provided for Dr Allinson.

The President: Thank you, good afternoon, Dr Allinson.

As with other witnesses, if you would kindly state your name and qualifications.

Dr Allinson: Certainly, my name is Dr Alex Allinson, I am the MHK for Ramsey, I am also a practising GP; and I am also the creator, amongst others, of this Private Member's Bill.

The President: Thank you.

Mr Henderson.

Mr Henderson: Gura mie eu, Eaghtyrane.

What I would like to invite Dr Allinson to do is to actually make some technical responses to some of the expert witnesses we have heard today, because they are professionally qualified and trained individuals with quite an in-depth knowledge of their subject. I think it is only right that Dr Allinson be allowed to make some commentary for the Legislative Council in response to some of those in relation to his Bill, to give us a balance on what has been put before us today and certainly in relation to the drug prescribing for pharmacists.

Specifically, I would like Dr Allinson to open with the professional bodies and other healthcare workers that he personally consulted with, just to advise the Legislative Council Chamber of the exhaustive process that actually you did go through, sir, and I would be particularly interested for a list of the professional bodies. I think I would be correct in saying that the Gynaecological and Obstetrics Society was also consulted upon on this road to the construction of the Bill.

So over to you, sir, if you could help us out.

Dr Allinson: Thank you, Mr President.

What I would like to do is thank the three previous speakers for their evidence. Each of them brings a different perspective on a common problem and I think one of the challenges for any legislation on abortion is that there are lots of grey areas. One of the grey areas we have talked about is the philosophical views of people, the religious views of people, but also sometimes the conflict between a paediatrician and a gynaecologist and also sometimes the conflict between the law and what happens in medical practice. And so I think each of these different perspectives bring something new to it, and I thank the Lord Bishop for providing this nuance.

If I can just start with some of the comments from Prof. Wyatt, and in no way do I want to cross-examine or criticise anyone, but just to fill in some of those gaps that Mr Henderson has asked for. At the start he was talking about input from gynaecologists and input from people who provide abortion services. BPAS were asked to take part in the public consultation of the Bill and actually fed in an awful lot of ideas, particularly in terms of serious social reasons, and gave a pamphlet providing some of the reasons that women might need late terminations for social reasons – because they were in crisis, because of domestic abuse or drug problems. So there was some input there from providers of abortion services as well as from the Royal College of Obstetricians and Gynaecologists, who were extremely helpful with their input.

I also went to London to meet with the Royal College of Midwives. One of their representatives came to brief Tynwald Members about the Bill. Obviously the Royal College of Midwives and now the BMA are arguing for decriminalisation and this Bill provides for that. And so the Royal College of Midwives were extremely helpful in terms of the wording of the Bill.

We have heard also from Dr Neal about issues in terms of conscientious objection. The first draft of the Bill went beyond the United Kingdom in terms of conscientious objection, and puts the emphasis on the person even if they had a conscientious objection to refer on. The General Medical Council thought that that may put doctors and GPs on the Isle of Man at a disadvantage because it was a higher bar than in the UK, and so the GMC gave a recommendation that that part of the conscientious objection clause be removed, and it was, and they were quite satisfied with the clause that now stands in the Bill.

Coming back to Prof. Wyatt's comments, he talked about some of the accuracy of dating scans and he is quite correct. Even with the best scanning equipment in the world you can get slight nuances in terms of the dating because some foetuses may be slightly small, some foetuses may be slightly large and it is the crown-rump length that we normally use to get the time limits. That is one of the reasons why the Bill separates the trimesters into three and has the 14-week limit for termination on request. We could have long discussions about whether it should be 14 weeks, whether it should be 12 weeks, whether it should be 10 weeks. The reality is the vast majority of terminations in the UK are carried out before 10 weeks. But what the 14-week limit does is give that scope between 10 and 12 weeks, if there is a variation with the dating scan, if there is some doubt of

the accuracy of the dating scan, it gives that leeway for clinicians to offer services to women; and I think it is that leeway which is really quite important.

He also talked about the upper limit, the 24-week limit being perhaps brought down to 22, on the grounds of foetal viability. During the discussions in the House of Keys we did talk about the EPICure study, we did talk about the fact that whilst the medical successes that he pioneered at University College have led to more very premature babies surviving, that is often at a risk of developmental delay and later handicap. So whilst we have in the UK the 24-week limit, it was felt very much that we should go along with that timescale. The reason is that whilst terminations over 20 weeks are very rare – and in the UK the latest figures say that about 2% of all terminations are over 20 weeks – all of those, really, are sent across to the UK to a specialist foetal medicine unit in the United Kingdom.

So when we are constructing our own legislation we need to be very cognisant of the legislation over there. Now, at the moment, we do have a slight disparity in that because our current legislation conflicts with the UK that theoretically doctors who refer over for late terminations may be committing an offence under the 1995 Act. When I consulted with the head of the Department of Women and Children's Health at the University of Liverpool, which most women are sent over to for late terminations, and when I showed him a Bill, what he said was that, 'From my perspective, it is important that any cut-off does not disadvantage couples when a diagnosis or decision is delayed for whatever reason. Families should not be forced to rush to decisions they may regret later on. I think your Reform Bill strikes a reasonable balance in this respect.'

And so what we are trying to do in the Bill by having these quite wide time limits is give the woman, and her family, and her partner the chance, and the time, and the space to make that decision for herself. And, as the Lord Bishop said, I hope actually that by having a broader abortion law on this Island we can actually have a far lower abortion rate than perhaps in the United Kingdom, because that pressure is then taken off.

As Mrs Sharpe was saying in her commentary and the story she told, for women at the moment seeking abortion the clock is ticking – they have to rush to make a decision, they have to rush to make the travel arrangements to go across, they have to rush to get the money together, and by taking that pressure off and providing really top-class counselling before and if necessary after, I hope we can allow women to make the right decision and the right long-term decision for them.

Prof. Wyatt also talked a lot about foetuses experiencing pain, and the Royal College of Obstetricians and Gynaecologists have published clear guidelines on this and on the fact that infanticide should be offered for late terminations. We also talked a bit about if the foetus was born alive during a termination, and obviously this is incredibly rare, but there are some very clear guidelines both from the Nuffield Foundation, in terms of ethics, and also the Royal College. What the amendment that was put into the Bill states is that if this should happen that obviously you treat the baby, the child that has now been born, but try to also bring into that that you would have to take into consideration the mother who had just given birth. And so if it was more applicable to go along the palliative care route, because the child had a major foetal anomaly, then that would be taken into context, and that gave that leeway.

Prof. Wyatt also talked about the long-term sequelae of abortion and psychiatric problems. The British Medical Association has been consulted throughout the drafting of this Bill and they represent all doctors, including GPs, in the United Kingdom, and also the Isle of Man Medical Society is their representative body. When they fed into the final draft they were quite clear actually that they felt, based on the Academy of Medical Royal Colleges report in 2011, which concluded that an abortion does not increase the risk of mental health problems, rather it is having an unwanted pregnancy that is associated with increased risk of mental health problems, regardless of whether the pregnancy was carried to term or terminated, and they were very much with that view. We know that some women do have long-term psychological and sometimes psychiatric problems after termination, but I would argue that that is far more because of the stigma and the shame that they face at the moment with the way things are handled; and, if nothing else, I hope that the

consultation and bringing this Bill to this Hon. House will have helped destroy some of that stigma forever and make right some of that shame that local women feel.

The Lord Bishop, during Prof. Wyatt's statement, said that the right to abort somehow becomes a duty to abort, and I do take on board his fear. Abortion should never be the default position ever. It is to my eternal shame that I have heard stories from women that when they have been faced with an abnormal scan, when they have been faced with a difficult diagnosis the doctor dealing with them has jumped to the conclusion that, 'You want an abortion, don't you'? I think that feeling of shame we need to address, and the way we need to address that is through decent training and decent counselling of women in those circumstances, but not by making access far harder and driving this underground. The reason that we have abortion reform is to save women's lives, because we know that illegal abortions kill women. What this Bill aims to do is reform our 1995 Act, which made abortion legal, but allow the access to those women who are currently having to go abroad for it.

Coming on to Dr Neal's statement, she is a member of the BMA Ethics Committee, although she was talking in her personal capacity, and I completely respect that. Again, the BMA Ethics Committee has done a submission regarding the Bill. They highlighted some issues in terms of if the child was born alive after a termination, they highlighted some issues in terms of termination of pregnancy on the grounds of sex of the foetus and they highlighted, as I have already said, in terms of abortion and mental health. They welcomed the clauses on access zones and they very much felt that this was a progressive move that they supported; but they particularly talked about welcoming the opportunity to comment on guidelines in terms of counselling and hopefully we can talk a little bit more about that because I think, with any difficult decision, such as termination, giving the woman the space, the time and the right information and counselling to make the right decision for them and their families is extremely important.

Dr Neal did talk about the revocation of the particular clause of the Infanticide Act and I had a long chat with the legal drafter, at an early stage, in terms of if this Bill was to come in which previous bits of legislation would need to be repealed, and this was certainly one he felt was extremely important. I think the essence of conscientious objection was dealt with really quite comprehensively in the House of Keys, and it is a difficult balance between somebody's private feelings and private beliefs, and also the necessity of providing healthcare services on the Island. I do think that we have that balance right in the Act, but I look forward to the Legislative Council perhaps refining that and getting that as good as we can. We do have an Equality Act and I think the passage of that has been a landmark for this country and I think that has very good provisions in it for safeguarding the rights of workers on the Isle of Man and for people who are coming here to start work.

I would like to thank Mrs Stapleton both for her input and also for putting me in contact with the Royal College of Pharmacists, who were extremely helpful and supportive of pharmacy prescribers. I completely understand her reticence and nervousness about this because, as she said, pharmacist providers are a new idea but are growing in stature in the United Kingdom. The essence of this legislation was not to say, 'You will do it this way; you will provide abortion services this way and these people you will want to do it'. The essence, that I am very thankful for the drafter to do, was to try to future-proof this legislation so that in the future, as we perhaps move more away from a very medical, doctor-based model towards teams lead perhaps by nurses, midwives, including pharmacists, to provide all sorts of different health services, that the legislation would not stop that. As Mrs Stapleton said, you cannot have pharmacist prescribers involved in abortion services in the United Kingdom because it is illegal, because they have a 50-year-old Act which makes it illegal. So what we are trying to do is look forward to the future and give the leeway for this provision, if it is felt right for the Isle of Man.

There are lots of different parts of the Bill which, as the Hon. Mrs Poole-Wilson said, say 'may'; and also in terms of those people who can take part in the provision of the Bill that is quite specified really, in clause 7, in that:

> A person may participate in the provision of abortion services if, but only if, that person is authorised by the Department, possesses the appropriate skills in relation to the gestation period …

– and then comes on to be registered.

Mrs Stapleton talks about the safety profile of mifepristone and misoprostol and her previous work in the World Health Organisation, and I understand that both of these are on their list of essential drugs. There are risks involved with all medications but medical termination is actually incredibly safe. One of the problems we have at the moment is by the time women from the Isle of Man get to Liverpool for termination, often it is too late for medical termination and they have to have surgical termination, which is far more dangerous for their long-term health. So by bringing this into the Island and providing medical termination at a time that is appropriate for that woman and a place that is appropriate for that woman, I think is a major move forward.

In terms of who else took part in the discussion with this, it was an open consultation and I would like to thank all the people who took part, the 3,600 individuals and the over 30 groups or professional bodies. But just to put it into context, we had the BMA Ethics Committee, the GMC, Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing and the Royal College of Midwives all fed into it, both in terms of at a national level but also, particularly with the Royal College of Nursing and the Royal College of Midwives, their regional branches here as well. And in terms of the British Medical Association, the Isle of Man Medical Society also submitted their views. So whilst exhaustive and exhausting, I hope that as many of the professional groups and as many of the people who will be asked to provide this service, should this Bill get Royal Assent, have been involved in the creation of it.

But one of the things this Bill does is create a legal framework for then the Health Department to provide the right services. And as we have heard, the services that we can envisage *now* may not be the services that we will be providing in the next 10 years. When the 1995 Act was passed, even then they were talking about what was called at the time RU-486, which is now known as the morning-after pill, and they were experimenting verbally with how services would be provided. I think what we are seeing now in terms of the legislation is creating the legal framework which allows for services to be provided, how they are found fit and suitable for the Island. And hopefully, if passed, that will give the leeway for those services to be provided in the right manner, but also future-proof it so that we do not have to come back again and again for changes in primary legislation to allow different people to do things in slightly different ways, as technologies advance.

Thank you, Mr President.

The President: Thank you, Dr Allinson.

Mr Henderson.

Mr Henderson: Gura mie eu, Eaghtyrane.

Thank you very much, Dr Allinson, for your response to comments from the expert witnesses called by the Lord Bishop.

I only have one further clarifying question and that is just to make sure we understand. If you can confirm this, you did consult with the staff at Noble's Hospital during the construction of this Bill and specifically family planning staff from the gynaecological unit as well.

If I have understood it correctly, you attended a staff meeting there to brief them.

Dr Allinson: Yes, that is correct.

What I did as part of the public consultation was arrange to meet at a branch meeting of the Royal College of Midwives, a regional branch meeting at Noble's where they have midwives working in the Family Planning Service there. I also met and gave a presentation to a meeting of the Women's Health Division, which included all the consultant clinicians and gynaecologists, to seek their support.

One of the statements made by Mrs Stapleton was why the 14 weeks for medical termination is in the Bill. That was at the request of some of the obstetricians and gynaecology staff who used mifepristone in surgical terminations as well, as part of that. Whilst the product licence is extremely important, you have already heard from Prof. Wyatt that sometimes drugs are used slightly off licence and so it is not uncommon to do slightly later medical terminations if it is felt safe and proper to do so. So that is why the 14 weeks was in there. It was really at their request in terms of they wanted that leeway to be able to provide that sort of abortion service using those sorts of products.

I also advertised, through the Department of Health and Social Care, two drop-in sessions for all members of staff at Noble's which were held during lunchtimes at Keyll Darree and at that point talked to people who represented the Family Planning Clinic, but also somebody from radiology who does ultrasound and explained it to them. It was very difficult to liaise with *all* the staff at Noble's, but I tried as much as possible to provide that forum for them, to hear what they wanted to say.

Mr Henderson: Thank you very much.

The President: Thank you.

Can I ask if there are other questions for this witness? Yes, Mrs Lord-Brennan

Mrs Lord-Brennan: Thank you, Dr Allinson.

Just to pick up what you said there about the 14 weeks and where that has come from – just correct me if I am getting this wrong anywhere – staff at Noble's who felt that they needed to have the use of that particular drug to do with surgical abortions. Given what we have heard about concerns that there seems to be a licensing cut-off for the combination medication, do we need to shift our thinking then in light of the licensing?

In the Bill when we are talking about medical abortions we are probably talking about the service provision that might be used the most, so I wonder whether we need to be taking our thinking on that from the licensing relating to that drug or from healthcare professionals that are actually thinking about it in terms of surgical abortions.

Dr Allinson: It is a very good question.

First of all, you are quite right that because of medical terminations being easier in some ways for the woman physically, because they do not involve general anaesthetic, they are increasing in popularity in terms of when women are given the choice they would often like to have a medical termination.

Part of that also is that particularly in Scotland they are now able to take the second dose of pills at home, so they do not have to come back to hospital, and that can be very important for some women who struggle with providing healthcare for their existing families or who do not want to be on a hospital ward for a day when they are having a surgical termination.

However, there are some women who cannot have medical terminations because of pre-existing medical problems like very high blood pressure or bleeding disorders, who may need a surgical termination. Similarly, some women may elect to have a surgical termination because they have been through a traumatic miscarriage before or they have had a traumatic abortion before. So you always have to give women that choice of different methods of terminating a pregnancy.

Coming back to your original question about how long or how late you would do a medical termination, when I have asked the local obstetricians about this, although the product licence which is written by the drug company is fairly restrictive, they will carry out medical terminations after 10 weeks if it is suitable for that woman and if the woman wants it. So that is why the 14 weeks was put in there – to allow that flexibility. But that is very much a clinical decision for the obstetricians involved and so the legislation is written very much with that in mind, as I said, to give that legal framework to allow doctors, midwives and nurses, and pharmacists if necessary, to do their job to the utmost of their ability.

Mrs Lord-Brennan: So it is really your intention that the Bill sets the outer parameters, not the expectation of the general use of 14 weeks?

Dr Allinson: That is quite correct. The Bill is a legal framework. The actual guidance in how services are provided will be within that legal framework, but it gives enough leeway for individual cases to be assessed; it gives enough leeway for services to develop over the next 10 or 20 years that may provide a different service in a different way to what we recognise at the moment.

Again, only 10 years ago medical terminations were perhaps 5% or 10% of all terminations; now they are 80% or even 85%, so things have changed a huge amount and, as Mrs Stapleton has said, with NICE reviewing their guidelines on terminations that may change again. So the legislation is not prescriptive, it is not saying, 'This is what you do,' it is actually setting a framework under which local services and local guidelines can be originated by the people who provide the service.

Mrs Lord-Brennan: So in essence then, once the Department of Health and Social Care take over the operational side they can make their own judgement on the best practice and the guidance, so it might not actually be 14 weeks but the law would not prevent it if it was.

Dr Allinson: That is absolutely correct. I did have a discussion, for instance, with one of the senior gynaecologists about the use of ultrasound. In the Royal College of Obstetricians and Gynaecologists' guidelines they do not feel that ultrasound is essential. There are various other tests.

Just a standard pregnancy test, they think is enough to then go ahead with the termination, but the local clinicians here want an ultrasound done – for a couple of reasons: they want to check on the gestation, they want to check that there is not an ectopic pregnancy or a molar pregnancy, and they want to be absolutely certain what they are dealing with.

Again, that is a local application of national guidelines and would be absolutely correct within the structure of the legislation, but it is letting clinicians actually provide what is – and I know I have emphasised this – a healthcare matter. It is creating the legislation that provides that space for clinicians to provide that healthcare to women on the Isle of Man, but within parameters.

Again, one of the things we talked about is that balance between the rights of the potential child and the rights of the woman. That is why this legislation was broken down into trimesters, to show that gradual increase in responsibility and that gradual increase in the need to take these ethical, moral and medical considerations into play.

Mrs Lord-Brennan: I think it is also known that there are different voices within healthcare that are perhaps not quite as on board as maybe some of the ones that were happy to participate in perhaps the early stages. When you consulted with them was that at the general public consultation stage or because the Bill has changed quite a lot?

Dr Allinson: The Bill has changed with the consultation, which is right and proper, that you consult, you take on board those comments and you change the legislation. You are quite right: without being flippant, the medical profession is a broad church and we contain people of lots of different backgrounds, lots of different belief systems, on abortion as well as lots of other factors, and I respect those viewpoints.

At the start of the consultation period I sat down with some of the people who wrote the open letter that you all received in terms of concerned healthcare workers who were concerned about the Bill right at its beginning. I sat down with them to try to allay their fears and explain why I thought changing legislation was important. But there will always be people within the medical profession who do not agree with abortion or do not agree with some of the time limits of abortion. That is right and proper, and that is why we have professional organisations to represent them and to have a more general view of how these ethical matters should evolve.

What I would say though is that it is Tynwald's responsibility to set legislation and it is the Department of Health and Social Care's responsibility to apply that legislation in terms of healthcare. So whilst I think it is very important that the views of medical professionals are taken into account, I do not think those have primacy over your discussions. That is whether that is myself or any other clinician. We all come with our own particular viewpoints and with our own particular ideas, but you as lawmakers are the ones that make the laws that then need to be applied by the services that are given taxpayers' money on this Island.

Mrs Lord-Brennan: Is it fair to say that although we are setting the legislative framework here, and I think that there is momentum for this to happen but there is actually still a fair way to go – because perhaps compared to, for example, obviously we have had the Abortion Referendum in Ireland and they have their draft legislation – that has had Department of Health input as we have gone along, meaning that the two stages of service, planning and considering how things will work, have been done concurrently. Our difference here is that once legislation is passed then it is firmly with the Department of Health to figure out how the service will work and all the details of that. So that is the situation that we are in.

It is not fair to ask anybody here when the provision for abortion services would be in place and I think obviously we are not hearing from somebody from the Department of Health and Social Care today because we could not because it would not be appropriate; but the expectation is there is a fair bit to be done, we can set the framework and that will be done.

Dr Allinson: Yes, I think there are two points there.

First of all, it is not uncommon that abortion reform is led by Private Members' Bills. Lord Steele, David Steele, at the time in 1967 brought a Private Member's Bill that revolutionised the abortion laws in the United Kingdom. I am not putting myself in the same case as him but there was a reticence in the Department of Health and Social Care to have this as a priority. So that is why it was a Private Member's Bill.

The difference between us and the Republic of Ireland is abortion is legal on the Isle of Man. It has been since 1995. We have a structure that provides for abortion, provides for medical abortion. They are happening perhaps today at Noble's as far as we know. Surgical terminations could have happened this morning as far as we know.

So termination is legal. What is hampering the cause and the plight of women on the Isle of Man is the access to those services. So whereas in the Republic of Ireland they will have to start from scratch and they will have really quite significant opposition from parts of the medical profession in that country to get the service up and running, we already have a service on the Isle of Man. We already have GPs who will advise women about termination. We have hospital consultants who are doing terminations. We have hospital consultants who are referring off-Island for late terminations and in the case of fatal foetal anomaly and also severe foetal impairment.

So we have that system already. What we do not have at the moment is access for the vast majority of women who need those services who are being exiled to the United Kingdom to pay for a private clinic there. That is what this Bill is about, it is improving access rather than revolutionising the provision of services because those already exist. Those will need extra resources, they will need extra staffing and extra training, but I do not think that that is outside the remit of the Department to bring those in if Tynwald so requests.

Mrs Lord-Brennan: Thank you, Dr Allinson.

The President: Thank you.

Are there other questions of the witness? Yes, Mrs Hendy.

Mrs Hendy: Thank you, Dr Allinson.

This may seem a very simple question and I do not know if I have missed it somewhere, but where does the responsibility lie to (a) establish that the woman is pregnant, and (b) how far into the gestation period she might be, especially if we are thinking in terms of the future and she might present at a pharmacy asking for a medicinal product? Where does the pharmacist … how far is he obliged to provide that? Does she have a certificate that she has obtained somewhere else to say how far she is into the gestation period?

Dr Allinson: That is a very good question. Again, the use of pharmacists and the ability for pharmacists to take part in the process was done not to say that this is a model that we should pursue but to say that we should not have legislation, as they do in the UK, which bans pharmacists from being involved.

In answer to your question, there are certain countries in the world – for instance, in rural Canada – who use telemedicine to do all the counselling, to do a lot of the work, and then would direct a woman to a pharmacist. Fortunately, the Isle of Man is a lot smaller than Canada and so I do not think we will have to use those sort of technologies here, but it may be in the future that a woman would been seen at Noble's Hospital, would have a scan there, would be prescribed medication, then would go and obtain it from a pharmacy close to her home rather than have to sit around in the pharmacy at Noble's. That may be, but again the legislation is not prescriptive. It is not saying that this is what you must do; what it is doing is creating a legal framework which allows these sorts of services to evolve perhaps in the future.

I do not think we will ever get to the stage where a pharmacist on their own would run an abortion service. We have heard from Mrs Stapleton about the limitations on that and the fact that pharmacists, nurses, midwives and doctors are used to working in teams. And so best practice would be, I think, on the Isle of Man to have ultrasound scanning to confirm gestational age, to have counselling and then to be given medications or go through with a surgical termination. What this law allows, though, is for the administration of those medicines to be done by a nurse or a midwife or a pharmacist rather than necessarily have to get the doctor back to actually hand them over to the woman. And so it frees up some of the problems we may face in terms of staffing a service on the Isle of Man.

Mrs Hendy: Thank you.

So you could not see a scenario where an older sister or a mother might appear at a pharmacy purporting to be the pregnant woman but it is for a younger sister?

Dr Allinson: I cannot, no.

The reality is at the moment we know a substantial number of women are buying pills online illegally and taking them. This is completely unregulated, completely unsupported. By and large, so far, it has probably been safe but we do not know how many women are coming into Noble's with a heavy miscarriage who have actually taken these pills.

How you provide abortion services to provide counselling to make sure that the woman is fit to have that healthcare, to have that procedure, I think is very important, but I cannot see in the future that you would have some anonymous 'turn up and get the pills' kiosk. No, I cannot, and I do not think the Isle of Man Government or the Isle of Man people would want that.

What we are trying to do with this legislation is create a framework which allows services to evolve on the Isle of Man which might be unique to our Island, which might be very different to the UK. I personally regret that in the United Kingdom over 80% of terminations are by private firms, by charities, rather than by the NHS, but that was a decision they made. What we have been quite clear about in this legislation is that terminations here will be done under the auspices of the Department; that really, with the small numbers of women involved, I do not see any private providers coming over here; that they should be done within the healthcare service and treated, like a lot of other services that are done, with the right security, with the right confidentiality, with the right respect

for that woman, but also the right safeguards in terms of the safety of that woman and the safety of staff to go about their business.

Mrs Hendy: Thank you.
And the finer detail will be embodied in regulations and guidelines in the fullness of time?

Dr Allinson: It will be. There are huge amounts of guidelines for the provision of abortion services from the Royal College, from the BMA, from the Royal College of Nursing, the Royal College of Midwives and from the British NHS, so we are not inventing the wheel here, but what we are doing is taking best practice and creating a service that suits the Isle of Man, both in terms of how it provides services for women on this Island and how it provides them in a timely manner. We need to also make sure that we can provide the resources available in terms of counselling, ultrasound, and perhaps surgical space. But talking to people who are running the service at the moment which is going on, I think they are up to that challenge and I think they can provide that with the right support of the Department.

Mrs Hendy: Thank you very much.

The President: Yes, Mrs Sharpe.

Mrs Sharpe: Thank you, Mr President – and thank you, Dr Allinson, for your information so far.
Just looking to the future, have you had any indication as to where funding will come from for this proposed service? Will the Department be expected to find money within its already stretched budget, or might Treasury make more funds available?

Dr Allinson: Again, that is a very important question because there are resource implications.
One of the aspects of bringing a Private Member's Bill was to get Treasury concurrence and to go to Treasury with an outline of how much this service would cost. I can cost it up – the costs for an ultrasound, the costs for the medications involved, which is around £12 to provide a medical termination, and we already know that we have the staff in there who are providing termination services. In essence, should the Bill obtain Royal Assent, it will then be up to the Department to say how they are going to provide those services, and if they can provide them under their existing budget, fair enough, they can do that. If they need a supplementary bid from Treasury, then they will need to go to Treasury.
I will be quite honest with you, that certainly talking to the consultant gynaecologists, they thought that there would need to be an investment of money to provide not only the counselling and training for staff but also the extra ultrasound slots that would be necessary, and there will be some consideration as well in terms of, if you have women accessing abortion services, how they are treated with the respect and dignity they require and not lumped in with some other antenatal or something like that, which might be wholly inappropriate for all people involved.
So there will need to be careful consideration about how the services are provided and there almost certainly will need to be provision for extra resources both in terms of staffing and finance. So, if the Department of Health and Social Care cannot provide that, they would need to go to Treasury with a supplementary bid. As I said, I think in terms of my conversations with the Department and with Treasury they are both more than aware of that.

Mrs Sharpe: Thank you.

The President: If there are no further questions – Yes, Mrs Lord-Brennan.

Mrs Lord-Brennan: Thank you, Mr President.

I know that this was discussed quite extensively in Keys what I am about to ask, but I just wondered if, Dr Allinson, you could summarise how parity or equivalence with the UK law and perhaps their interpretation of that, based on the fact that it is somewhat outdated, is achieved through our Bill, with particular reference to later-stage abortions and, separately, social grounds.

Dr Allinson: Certainly. You are quite right; the UK legislation is 50 years old this year. At the time when it came through it was revolutionary. Looking back on it now, it is dated but one of the problems with abortion politics is that it is quite hard to change primary legislation, so you need to try and get it as right as you can the first time.

In terms of terminations, as I said, the statistics from England and Wales show that the vast majority are done through medical termination, which could be done on the Island. The vast majority are done relatively early. The latest figures show that 81% were done between three and nine weeks, another 11% were done between 10 and 12 weeks, and then 13 to 19 weeks was about 7%, with late terminations being very rare.

Should a woman need to be referred to the United Kingdom for a later termination – so, over 19 or 20 weeks – they would then be assessed by UK law. You are quite right, our law being slightly different in terms of significantly talking about social grounds would be different to UK law. However, UK law takes into account the mental health of the woman and the health of the woman and her family. So, to have a serious social ground that would necessitate a clinician agreeing to a late termination would almost certainly comply with legislation in the United Kingdom.

Again, that is one of the reasons why I think it is very important that we keep our limit at 24 weeks, so that a woman who is 23 weeks who then finds that they require a termination can have that done legally in the United Kingdom if they have to wait for another week to arrange transport to go to a specialist unit, and there is nothing in our provisions which would act against somebody having a late termination in the United Kingdom. To have a termination there involves a conversation between clinicians here – senior clinicians often working as a team – and a clinician over in a specialised foetal medicine unit.

The reason late terminations are done in the UK is because they incur far greater risks to the woman herself. They often involve techniques such as detailed scanning or infanticide, which we do not do here on the Island, and also they need the team who can give the right level of counselling and support before, during and after the termination, which again we do not have here on the Island.

So I think it is wholly appropriate that these are done across, but there is nothing in this Bill that would cause a major conflict with the United Kingdom and certainly that was something borne out by my discussions with the General Medical Council, the BMA and the Royal College of Midwives, that they felt this Bill would dovetail into current provision in the United Kingdom rather than unnecessarily conflict with it if women had to go to England for a later termination.

Mrs Lord-Brennan: Thank you, and the idea is for the continuity of care to continue even though a procedure might be carried out in the UK, whereas at the moment I think the situation could even be that a doctor may not be able to refer in some cases, or if they do they have to be paid to say, 'This woman has not had a period', and that is it. So they could come back and have the continuity of care, and that is the good reason behind the scope of up to 24 weeks, even though we may not provide it here.

Dr Allinson: That is correct. We are talking about a tiny number of women from the Island that would be included in late terminations. Each one is an individual case that needs to be judged on its merits ethically, legally and medically. The reality at the moment is we may have women going for late terminations who do it completely privately. We know nothing about it. As a GP, I have found out about my patients having terminations in the United Kingdom purely by accident when they have come back a year or two later and told me. There is no continuity there. There is no support there. There is no understanding there either in terms of supporting them through the process or

afterwards in terms of contraceptive services. So by being honest about abortion, being honest about the provision of abortion, I hope we can support those women throughout the process and provide the continuity they need, but also that they deserve.

Mrs Lord-Brennan: Thank you, Dr Allinson.

The President: Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President.

You mentioned, Dr Allinson, that with late terminations … We have talked about counselling and in the Bill it seems to me it is information provision before and afterwards. When it comes to late terminations, that counselling, that term seems to then change, doesn't it, because then you are talking about mental health assessments, etc? What is the differential there?

Dr Allinson: The counselling for a later termination has to be different because the procedure itself is completely different. The reasons behind it may be very different as well, in terms of a woman in crisis, a woman who has found that – a wanted pregnancy up until then – there is something really quite seriously amiss.

Again, coming on to one of the comments from the Lord Bishop, termination should never be a default position in terms of foetal anomaly but, as we have heard, it has to be an option that is presented by clinicians because not to do so would disadvantage that woman or her family.

I would agree with Prof. Wyatt that this can be very difficult, and in some ways yes, in an ideal world ignorance would be bliss, but actually doctors are not the ones who can make patients ignorant anymore. We have to give people all the options – and we should do, and they should be presented with them.

So I think it is very important for people to have those options. If, for instance, you are 24 weeks pregnant and something catastrophic is found with the developing pregnancy and termination is given as an option and you want to explore that in more detail, you would be referred to a foetal medicine unit for that specialist termination counselling, to go through the options available to you with people who do that all the time, because the clinicians here do not deal with late terminations and the staff may not be *au fait* with the information that they need to give.

Again, for late terminations – which are incredibly rare, less than 2% of all terminations and very late terminations even rarer – I think those need to be done in the proper way with the right respect to the woman and to the foetus as well.

Sometimes women will elect not to have a termination and will give birth at that specialist centre because they know that the child can then go on to specialist support, can then have the three operations it needs to survive the first month, or perhaps then it can receive the palliative care that it needs from a local hospice. Again, that is sometimes provided on the Island. Thankfully, it is rare, but women do give birth to children on the Island when they know that there is no hope for their long-term survival, and organisations like Rebecca House are fantastic in terms of supporting that family through what can be an extremely difficult period for them, watching a very much wanted child die at a very early age.

Miss August-Hanson: Just on a different subject matter but still relating to counselling, were at any point partners considered? Was it considered relevant that partners to the women that would be on track to … or looking at abortion services, that it would be made available to them as well?

Dr Allinson: I think that is a very good question.

You need to be careful, because what the Bill also provides for is protection against coercion and that was something that came out during the discussion in the Keys, that unfortunately we live in an environment still where some women may be coerced into having a termination by a male partner, whether that be the boyfriend, husband or male figure in the family, a father or an uncle. And you

have to be very careful about that. Best practice is always to give counselling to the woman on her own; however, with her consent you could involve her partner with that as well.

Whether specialist counselling would be provided just for the partner, again you need to be careful about that in terms of boundaries and medical confidentiality. But it is certainly something that could be provided; and although it is not specified in the Bill certainly it could be provided as part of a wider sexual health strategy.

Miss August-Hanson: Thank you, Dr Allinson.

The President: Are there any further questions?

In that case, can I thank you, Dr Allinson, very much for coming to the Bar of Legislative Council this afternoon; and thank you for your evidence. Incidentally, Dr Allinson, as a Member of the other place, appears under the authority of Mr Speaker as well as the President, as having the right to be heard under our statutory provision of the 1919 Constitution Act which has been very rarely exercised.

So thank you very much for your attendance.

Mr Henderson.

Miss August-Hanson: Forgive me, sorry, Mr President, but I have not been able to speak to my witness yet.

The President: I am giving Mr Henderson the opportunity to conclude this particular part of his presentation, if he wishes.

Mr Henderson: Thank you, Eaghtyrane.

No, I have got nothing further to ask Dr Allinson or any other expert witness. I am quite happy for Miss August-Hanson to progress with her witness.

The President: Thank you.

Miss August-Hanson.

Miss August-Hanson: Thank you, Mr President. And thank you, Mr Henderson.

I would like to be able to ask Debbie Morrissey, if I could, to speak with your permission.

The President: We are calling a further witness so if the microphone could be presented to Ms Debbie Morrissey.

Ms Morrissey: Thank you.

The President: I bid you good afternoon and invite you to state your name and position, please.

Ms Morrissey: I am Debbie Morrissey. I have been a counsellor for 30 years and I am presently working with the Psychology Department on the Isle of Man; I have been for 19 years. I worked for eight years for Marie Stopes in the abortion department.

Miss August-Hanson: Just to be clear, now you work for the Department of Health and Social Care?

Ms Morrissey: Yes, I do.

Miss August-Hanson: The provision that we currently have in place, can you give me a description of that and where you feel that we are at the moment, whether or not we are coping at the moment?

Ms Morrissey: Do you mean just to do with the abortion generally? (**Miss August-Hanson:** Yes.)

At the moment if a woman is ambivalent about her pregnancy we will see her instantly, as soon as she can get to us actually. We will make provision for that. We also see people after abortion, so when they come back. They can book it before they go or they can book it when they come back from having an abortion. That bit is on an individual basis.

If somebody has had an abortion 20 years ago and it is coming out as an issue and they want to talk about it we just see them as a normal client. So everybody is seen.

Miss August-Hanson: The provision at the moment in terms of counselling, that is an information-type service or what service is it?

Ms Morrissey: No, it is counselling.

Miss August-Hanson: How would you describe that?

Ms Morrissey: I can give a certain amount of information because I worked in the abortion service, but it is counselling to help them decide what they want to do. So we go through all the options and what it is going to mean to them in the future and their families.

Miss August-Hanson: Is it different on each individual basis as to how much they need as to what you would provide? Can you give me an answer?

Ms Morrissey: I am only going by what I have provided with permission of my Department and I could see a woman probably up to three times before she needed to go away.

Miss August-Hanson: So you would provide information leaflets about a variety of different subject matter? What types of subject matter would you provide information about?

Ms Morrissey: It is not so much about information, it is counselling to find out what it is the woman needs and wants for herself.

Miss August-Hanson: I think there has been some confusion I suppose in terms of the actual word 'counselling' and what the word 'counselling' means. What does it mean in terms of what you do at work?

Ms Morrissey: I am a humanist-based counsellor. I am registered with the BACP. I actually trained at the same time as working for Marie Stopes. They paid for my training with the Centre for the Advancement of Counselling.

The way I work is just finding out what the person wants to deal with. So I am in the room with that person, I am understanding what that person wants, but I can be a bit challenging as well. I can maybe read between the lines and think, 'Well, have you thought about this and have you thought about that? What would happen if your partner left you?' Or what would happen if they are with the wrong partner? Any multiple variants of life, really.

Miss August-Hanson: You have some experience of working in the UK as well and working with Marie Stopes. Can you describe that type of work? What type of work you did there?

Ms Morrissey: I worked in the consultation bit, so women would come in, they would fill in a form and they would see the doctors. Some of the doctors were counsellors as well; they trained as counsellors, so some of them would do the counselling *and* the medical bit; and I would do counselling. I did also some training with the staff about communication and how not to put your own ideas of what should be on to the clients.

Miss August-Hanson: Did that work differ between what you were doing then and what the service provision is at the Department of Health and Social Care, where you work now?

Ms Morrissey: No.

Miss August-Hanson: No. So it is quite similar, quite the same?

Ms Morrissey: Yes, because if somebody comes into your room they are there because of what they bring and their problem, whether it is termination or whatever, so it is just two people in a room working stuff out together.

Miss August-Hanson: You have had a good look at the Bill itself, have you not?

Ms Morrissey: No, I have not.

Miss August-Hanson: You have seen parts of it?

Ms Morrissey: Parts of it, yes.

Miss August-Hanson: You have listened to the debate? We have all heard it. (**Ms Morrissey:** Yes.) What sort of challenges do you think that it may bring to the provision that we have at the moment in terms of expanding that service to meet demand?

Ms Morrissey: I am only looking from my point of view or the counselling point of view. It is getting enough counsellors. It is getting people with the right training, because I see people at the moment purely because of my experience and my previous training. So you would have to have more.

Miss August-Hanson: What would be encompassed within that training and where is that training provided? Do you know?

Ms Morrissey: Not here at the moment. One of my colleagues, the latest fully trained person, had to fund herself to go across to Manchester because she wanted to become a fully qualified counsellor. There is not anything on the Island.

Miss August-Hanson: What do you think would need to happen? Do you have an idea of what would need to happen, in your own opinion, not necessarily the opinion of the Department?

Ms Morrissey: It would be fantastic if training was provided over here. That would be amazing, because to get fully trained people who then want to – that is any aspect of the National Health – move over here to work is a bit difficult really.

Miss August-Hanson: What would be encompassed within that training?

Ms Morrissey: I think it would have to have the basic counselling training, and then added on to it all the different ways of having to be with somebody who is pregnant.

Miss August-Hanson: The provision or what you have seen across in terms of what you have heard about the Abortion Bill, do you feel that it is workable here?

Ms Morrissey: I do, yes.

Miss August-Hanson: And in terms of the stages of pregnancy as well, certainly with the 14 weeks?

Ms Morrissey: Yes, absolutely.

Miss August-Hanson: You have no reservations about it whatsoever?

Ms Morrissey: No.

Miss August-Hanson: None?

Ms Morrissey: I have had in the past but I like to process things. I am okay now.

Miss August-Hanson: What were those concerns that you had?

Ms Morrissey: Why 14? Because I worked in Marie Stopes, so we did not have that cut-off point. But I can see how it would work here.

Miss August-Hanson: When it comes to mental health, how much is there a clear pathway at the moment in terms of people in need of it that have had abortion services provision? Is there a clear pathway into mental health?

Ms Morrissey: It is not mental health, it is the counselling service. Mental health is something different. So if somebody had need for that they could be referred. They are our colleagues as well so it would be very easy and very smooth.

Miss August-Hanson: Should they be in need of a mental health provision, because we have heard of course of some instances where women have needed longer-term support, is that readily available at the moment? Do you feel there is enough resource?

Ms Morrissey: Yes.

Miss August-Hanson: Yes, okay. Thank you very much. I appreciate that.

Mr President: Thank you. Are there further questions?

Mr Crookall: Mr President, could I just ask for clarification, please?
I think you said somebody might come and see you up to three times before they went away?

Ms Morrissey: It is very rare. It is usually once. I am just thinking of one person at the moment.

Mr Crookall: Okay, but if it was three times how often would that be? Weekly or fortnightly? Do you give them times?

Ms Morrissey: No, not that long. The time thing, you need to see them fairly … just to give them time, but I usually see people once or they only want to come and just talk about what they have been thinking anyway.

Mr Crookall: Thank you.

The President: Mrs Hendy.

Mrs Hendy: Thank you. It is helpful to have your coalface experience really.

You mentioned when you were at Marie Stopes some doctors could counsel if they were trained counsellors.

Ms Morrissey: Yes, a lot of doctors do … we had quite a few 'obs and gynae' people who also worked at the ECA only around the corner and quite a few of them took on the counselling courses as well so they could counsel and do all the medical stuff at the same time.

Mrs Hendy: So every client that would appear would have the opportunity to speak and be counselled by a trained counsellor?

Ms Morrissey: Yes.

Mrs Hendy: So that might not just be a five-minute appointment?

Ms Morrissey: No.

Mrs Hendy: It would be a proper consultation?

Ms Morrissey: About half an hour to an hour, yes, and they can come back if they want. If we did not think they had made their mind up we would invite them to go away for a little bit and come back – which was a bit difficult when people came from abroad. They came from South Africa and Ireland, obviously, and lots of countries. They were on a time constraint, but even then we tried to have them counselled, go away and then come back again.

Mrs Hendy: Thank you. That is very helpful.

The President: Thank you.

If there are no further questions, can I thank you very much, Ms Morrissey, for giving evidence to us this afternoon.

Thank you.

Ms Morrissey: You are welcome.

The President: Miss August-Hanson.

Miss August-Hanson: I am content, thank you, Mr President.

The President: Mr Attorney.

The Attorney General: Thank you, Mr President.

Should the Bill pass its Second Reading today and we move on to consider the clauses stage I will be asking, as you will see from the Order Paper, for quite a significant number of amendments to be considered. These amendments are all designed to improve the Bill's provisions by perhaps providing better clarification or to remove uncertainties.

I would like, Mr President, if I may, very briefly to explain my role as Her Majesty's Attorney General in considering this matter, which must be limited to simply providing legal advice to the Members of Council in its consideration of the Bill. I am obviously concerned and have been

concerned to consider the matters with reference to the Equality legislation, which I will mention briefly in a moment, and also with reference to human rights, which again I will mention, because part of my role as Attorney is to advise with reference to legislation which comes forward for consideration to ensure that it does comply with human rights legislation, because at the end of the day I have to sign off with the Ministry of Justice my view as to compliance.

That said, I must also take this opportunity of saying I must, and do, step back from expressing any personal view or opinion with reference to abortion; and certainly I will not be commenting, and have not commented so far, with reference to any moral or ethical implications or any of the points raised. As has been demonstrated from the debate today and what we have heard from Prof. Wyatt, and from what we know from the careful consideration of this matter by the House of Keys and the responses to the far-reaching consultation carried out there are, and there will remain, differences of opinions. Those different views have, and I am confident will, not impact on this our caring Island when this Bill completes its passage through the legislative process. What is clear, however, and what has been acknowledged is that our existing laws are outdated and that our existing abortion law needs to be changed. How it is changed is a matter for you, Council, and for the House of Keys.

As the law currently exists, I am of the view that it is certainly challenging the human rights of a woman who is pregnant and for this reason I, as Her Majesty's Attorney General, offer my support to the Second Reading in the sure knowledge that Council will give its detailed consideration of the clauses of the Bill and their implications.

We have heard from Dr Neal earlier today and, like other Members of Council, I am grateful for her careful consideration of the Bill and for her expressing her views and opinions as to how certain aspects of the Bill might be considered. A number of the issues she raised I can deal with very quickly. She made mention of clause 29(b) at page 22 of the Bill which aims to repeal section 4 and subsection (2) of the Infanticide and Infant Life Preservation Act. The removal of those provisions specifically relates to section 71 of the Criminal Code which is repealed under the Bill and will be replaced by the Bill with appropriate modern provisions. The defence of child destruction in section 3 of that Bill is preserved so we need not be concerned in that regard.

Clause 12(a) of the Bill, Dr Neal raised a concern about imposing a duty on the medical practitioner, midwife or nurse attending, after discussion with the woman, to take all reasonable steps to preserve the life of the child. If the child was born alive, the child has the right of protection under Article 2, and this subclause 12(a) is therefore in reality merely restating the position under Manx law. The words in section 12(a), I note from the deliberations in the House of Keys were added by them no doubt to emphasise the position and the importance of that provision and I see no objection in law to that.

Dr Neal spoke for some length with reference to conscientious objections and I have a few words to say about that, if I may. She supported the amendment which the Lord Bishop will seek to move by introducing a new clause 8(2) which essentially was aimed to ensuring that there was no discrimination with reference to people applying for employment with reference to abortion services. That raised issues as far as Dr Neal is concerned with reference to the Equality legislation. I am satisfied that the general prohibitions on discrimination under our Equality Act will not be trumped by the provisions of the Bill. In view of the Island's socio-economic position, I view the fact that the matter of the provisions of the Bill will represent a proportionate means of achieving a legitimate aim which constitutes a basis for exception from the Equality duties under the Act.

Dr Neal also raised concern with reference under clause 8 to the creation of an offence, and this was in respect of an offence – and I will go to it – of:

> Any relevant professional or pharmacist whose failure to act in accordance with subsection (4) or (5) results in the woman suffering injury or the loss of her life (or both) commits an offence.

I see no harm in the introduction of that provision which again was debated at length in the House of Keys; and in fact it adds weight to the Department's position and is designed, I would imagine, to avoid it being at risk. Of course it is a matter for any professional person or pharmacist to comply with that provision, or if the circumstances so dictate to have asserted that they have

conscientious objections if it applies in their particular circumstances, to so acting in abortion services.

Dr Neal also made reference to her concerns with reference to the definition of 'treatment' and on reflection I agree with the concerns that she raised, and I understand that Dr Allinson, as the mover of the Bill in the House of Keys, will be happy for me to move a further amendment to address the concerns which Dr Neal has raised.

I want to mention *very* briefly the evidence that we heard from Mrs Stapleton, and really to emphasise the point which I understood the President was taking us to which was supported by Mrs Poole-Wilson. Clauses 5 and 7 of the Bill are in effect enabling provisions and it would appear that the mechanisms of what will be section 5 and clause 7 are much tighter and stronger than relying upon guidance. At the end of the day, it is the Department which will have to give approval both under clause 5 and clause 7 and it will be incumbent upon them in the exercise of their statutory duty to ensure that guidance is followed.

Thank you.

The President: Thank you, Mr Attorney.

Are there any other contributions from Hon. Members?

Yes, Mrs Poole-Wilson.

Mrs Poole-Wilson: Yes, just briefly, Mr President.

I just thought going back earlier to perhaps where the Lord Bishop started on something of a journey today on asking for certain reflections around the Bill. I just wanted to say that the starting point was almost where there is a divergence of moral perspectives on a piece of legislation such as this. The Lord Bishop pointed out that there is a duty there to try and seek some common ground, to work towards some common ground, and to try to achieve some consensus. I think it has also been acknowledged this afternoon, and I think the Learned Attorney made the point very well, that it will be impossible with a piece of legislation like this to achieve absolute unanimity. But we should be able to achieve consensus around a reform that works for our Island.

I wanted to reflect on the fact that the Lord Bishop has asked us whether in our debates and our consideration whether the voice of the mother has in fact become the dominant voice that we have heard, perhaps to the expense of other voices and he referred to the 'junior life'. And I have been reflecting on the fact that I wonder whether the fact that we have listened so much to the mother's voice in our debates is possibly a reflection of our history – our history that perhaps we have not listened sufficiently, historically, to the mother's voice and we are now at a point where we are trying to listen very hard to that voice. In saying that, I do not dismiss in any way, that junior life. I think the reality is that in trying to achieve some sort of consensus around reform we are trying to listen to a voice that perhaps we have not listened to enough in the past.

But what I would say – and I think the Keys' position, the consensus reached in the House of Keys and that we see reflected in the draft Bill, which we all acknowledge still has some amendments to be dealt with in order to make it the good and workable law that it should become – I think that consensus has been built around, not a purist or absolutist approach at either end of the spectrum. So we are not at a point where we say, 'No, there are no circumstances in which we can envisage providing abortion services'; but equally we do not have *carte blanche*. We are not saying, 'absolutely, in any circumstances whatsoever', should there be access to abortion services. I think we are reflecting, as the Lord Bishop has said, *realpolitik* and a gradualist approach. The challenge for all of us is around where we put some of those parameters.

But I do strongly believe … and I think we have had the benefit of hearing a lot of evidence today to help, certainly me personally, come to a point where I feel very strongly that the Bill we have and the reform we are looking at actually is in the right place because it *enables* – it does not tell, it does not require, it does not force, it *enables*. It enables each woman in her particular circumstances to access the advice and the support. It must be backed up, as we have heard, by proper provision in practice, including impartial counselling, including access to all support. But I believe we can do that

– I hope the will of the Department of Health is to do that – and I hope that gives comfort to some who are worried that this perhaps goes beyond where they would like to see reform, that actually this is just enabling the unique circumstances of each case to be properly considered by professionals who are trained and able to give that consideration.

Thank you, Mr President.

The President: Mrs Hendy.

Mrs Hendy: Just briefly, Mr President, thank you.

I think I am not alone, having discussed this with my colleagues earlier this morning, that some of us did not get much sleep last night knowing we were coming in today to consider such an important piece of legislation and the gravity of the decisions that arise out of this. However, I do thank everyone who has given evidence to us today and assisted us because it has helped me resolve some of the questions in my own mind, and I think put me in a better place to fully consider the Bill as it stands today, which I have to say was fully debated in the Keys. I think the debate we have had today hopefully has added to that debate and consideration, and will again help inform us where we go from here.

One of the reassurances that I feel as well is that we, having known women who went off this Island years ago to procure abortions and the trauma that they suffered, and the experience that stayed with them and the stigma and the secrecy that surrounded that process, I am convinced we can no longer persist with such an environment and we need a Bill that addresses a modern situation that does consider the child, but the mother as well. And I say it in that order because, as Mrs Poole-Wilson has said, the child has always been at the forefront of people's minds in the past and we have to open our minds to the mother's situation.

I think counselling is going to play a very important part in the actual practicalities of this Bill in reassuring women that they are presented with all of the options and alternatives to abortion as well, before they make that very important and critical decision. However, I think the Bill, once it is amended, is now in a state that I think I will be able to support today and I will be supporting the motion today.

Thank you.

The President: Can I call on the mover to reply: Mr Henderson.

Mr Henderson: Gura mie eu, Eaghtyrane.

It has been a long and interesting day and debate and I thank everyone who has had a contribution, observation, and I especially thank our expert witnesses, one and all, who have presented today and taken the time to sit through the entire session and take that interest. I am especially pleased with fellow colleagues, if I can call it that, from the nursing profession, who I am especially pleased to see in the Gallery and have had the courage to present. It is not very often we do have nurses presenting to Legislative Council or Tynwald; it has happened in the past by a certain Hon. Member.

Moving on, Eaghtyrane, in responding to the debate in general terms, I think what I would like to say first is one or two issues are still surfacing that I would like just to place a little reassurance on, and that is departmental commitment. At First Reading I read out a statement that I had eked out from the Department after quite a lot of communication with them and had their formal permission to use and place on public record here, and that was that once the Bill is enacted, the Department is committed to bringing in the effects of the Act as quickly and as smoothly as possible. That is on the public record. That is their statement and their commitment as far as they are able to give. So I think that is pretty good and it is there as a measurement now, as far as that goes.

When we think about today, I would ask all Members to think back to the First Reading and Dr Allinson's original points for bringing the Abortion Reform Bill to the House of Keys and indeed for the Island to consider.

I would ask Members to consider the statement read by Mrs Sharpe. That encapsulates, really, the real reasons why we are here today. I think we need to rise above the detail. There has been some technical detail today and I think what we are doing on the Second Reading is looking at the principles. We need to think why we are here, and it is my view that Mrs Sharpe has encapsulated that, absolutely spot on, in what she was saying. I too, as an ex-healthcare professional, can report similar circumstances, and the Bill on the Second Reading has wholeheartedly, obviously, my support.

The issue with consultation has been talked to, and so on. I think Dr Allinson has eloquently illustrated the extraordinary lengths he has gone to to talk to all the relevant professional bodies, registration bodies, medical bodies, healthcare bodies, to the point of meeting the national registration bodies, not just locally; attending staff meetings, holding open days at the Department of Health up at Noble's Hospital which the Department itself advertised to all staff at Noble's Hospital, again I think showing a commitment. So I think we need to take that into account, that in fact there has been an extraordinary amount of communication going on. As with any legislation, you are not going to please everyone 100%, but I think Dr Allinson has attempted to reach out as far as he possibly can and he has given us the feedback from certainly the family planning and gynaecological department.

In relation to resources, this Bill has Treasury concurrence. The Department have made a statement inasmuch that they have no reason to object to this on financial resources grounds, and in fact Dr Allinson has provided some costings based on figures and what procedures cost at the minute, which do not seem unsurmountable – far from it; and in fact I think the Department would be looking to meet the costs from its own budget to start with, and they are not being flagged up as huge, if I can put it like that.

Dr Allinson has answered the 14-week issue very well and put on record that that is clinician-based.

I think, really, all I need to point out as well is that the Third Reading of Keys, just by way of demonstration, was almost unanimous, bar two, so the resounding support in the Keys is large and that was the final result on the Third Reading. I think there was some mention of voting numbers earlier.

I think that is all I need to say, Eaghtyrane. I thank everyone for their contribution, I thank my seconder, and I would ask all Members to consider the opening statement by Mrs Sharpe.

The President: Hon. Members, the motion is that the Abortion Reform Bill be read for the second time. Those in favour, say aye; against, no. The ayes have it.

A division was called for and voting resulted as follows:

FOR	**AGAINST**
Mr Cretney	The Lord Bishop
Mrs Poole-Wilson	
Miss August-Hanson	
Mrs Sharpe	
Mr Henderson	
Mr Crookall	
Mrs Lord-Brennan	
Mrs Hendy	

The President: The motion carries, 8 votes to 1. Thank you, Hon. Members.

We move now to the clauses stage and I trust Hon. Members have the concatenated list of amendments.

Mr Henderson: Mr President –

The President: This is the latest list as put online as late as this morning, and it is the one that starts 'Amendments to clause 2'. That is where it starts.

As you will see, Hon. Members, to the clauses a considerable number of amendments will be voted on. Many of them lend themselves to be voted on in groups and when it comes to voting I will explain how that will be done in relation to each clause and set of amendments.

So, with that, Hon. Members, I will call on the mover, Mr Henderson, to start to move the clauses, starting with clause 1.

Mr Henderson: Gura mie eu, Eaghtyrane. I was trying to catch your attention, and I am sorry to have interrupted your opening speech there in relation to moving the clauses.

There seems to be a little concern within Council with regard to the number of clauses that have been corralled so far. There are also further clauses that have been identified that are not on the marshal list at the minute and that may well be, possibly, as of this morning, moved at the Third Reading. There have also been issues flagged as we have progressed our debate today which may cause further amendments to be produced at some point and I think I need to take direction, Eaghtyrane – or if you could ask Council – as to whether we should actually progress the clauses now or leave it until after next week to allow time to get things more correctly marshalled, further amendments put together, and then there may well be a move for us to possibly sit an extra sitting as well at some point to try and make back some time, if I can put it like that.

The President: The answer is quite straightforward. The progress of this Bill is in your hands, and if you choose not to move clauses today and you have given the reasons for that, that is perfectly straightforward.

I had not expected that we would be advised that there would be further amendments to come, and having been given the reasons it would seem sensible to delay the commencement of clauses until our next regular sitting.

Mr Henderson: I hear what you say, Eaghtyrane. I would be interested to just get some guidance from colleagues. I have got soundings of what some think, but –

The President: Well, the position, Hon. Member, is straightforward. If you do not wish to move the first clause, that is entirely up to you. There is no necessity to consult the membership of Council.

Mr Henderson: I am in an invidious position, Mr President, because I have been asked by some Members perhaps that leaving it for a week would be better for procedural reasons, which I can fully understand because there are more amendments coming along; and other Members are saying that I should make a progression.

The President: The next sitting of Council, of course, is 26th June, and that would be our next regular sitting. I think the position would be for you to move that the clauses stage be held over until the next regular sitting, which will give plenty of time for amendments to be drafted, if there are to be amendments, for them to be circulated to Members and to the public in sufficient time, without any more last-minute concerns being raised.

If you would care to move, then, that the clauses stage be taken at the next regular sitting –

Mr Crookall: Mr President, before we do, can I just make a suggestion maybe that … Mr Henderson mentioned before about maybe finding an extra day next week, depending on the length of Tynwald.

The President: The sitting of Tynwald is scheduled Tuesday, Wednesday and Thursday next week and I have no certainty when it will end. I am not inclined to advise a sitting be held next week, given

the need for adequate notice and adequate preparation of Members and for the public to know when that sitting will be. I will not know when that sitting will be until Tynwald concludes and I will not know when Tynwald concludes until it concludes, which might be Tuesday night, might we Wednesday night or it might be whenever. So there will be no sitting next week.

I do suggest that if Mr Henderson wishes to delay the moving of the clauses to the next sitting, that it is the next regular sitting, on 26th June. Do you so move, Mr Henderson?

Mrs Poole-Wilson.

Mrs Poole-Wilson: Mr President, if I may, just a question for clarification.

I think I understand why the mover feels in this invidious position, because in part it is about progressing the Bill; the other part of it is discussions with the legislative drafter. We have a lone drafter on this Bill with a large number of amendments (**Mr Cretney:** Hear, hear.) and I think one of the reasons we are now dealing with a large number of amendments in this Council is because of all the work in the Keys – good work, but the follow-through of all of that work has necessitated a very close read of this Bill with now consequential amendments.

So I think the feeling of some of us, certainly, in Council – perhaps most of us – is we would like to make sure that the amendments in due course absolutely work coherently so that the Bill that we return to the House of Keys is a coherent whole and does not require that.

On the other hand, I understand that for us to delay until our next sitting to start clauses obviously then puts back the potential for a Third Reading. So my question is: if we then wish at our next sitting, having progressed through the clauses stage, to agree an extra sitting, would that be something that as Council we could – ?

The President: Well, you will have advanced the progress of the Bill by a matter of days only. It is clearly coming back to Keys for agreement or not with Council amendments at their first sitting in October. You will at most advance the cause by one week by doing that because after 26th June our Third Reading would be our first sitting in October, so the gain would be absolutely marginal.

Mrs Poole-Wilson: But it would be open to us to determine an extra sitting if we wished to?

The President: It is open for a motion to be tabled.

Mrs Poole-Wilson: Thank you, Mr President.

The President: Yes:

> The Legislative Council … shall sit on such days, and at such hours, and in such places as the President of Tynwald … may determine.

So a motion may be made and a determination will be made.

Mrs Poole-Wilson: Thank you, Mr President.

The President: Mr Henderson.

Mr Henderson: In that case, Eaghtyrane, as uncomfortable as I am with not being able to progress further, but given that there are further amendments to be made – albeit typographical, as I understand, not major changes, but nonetheless they have been identified and there may be one or two others as a result of the issue of … Dr Neal raised it earlier – then I think it would be sensible for us to adjourn the clauses stage until after Tynwald sitting next week, to the following week.

The President: Is that agreed, Hon. Members?

Members: Agreed.

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The President: Thank you very much.

That being so, the business before us today is concluded and the Council will now stand adjourned until our sitting in Tynwald Court at 10.30 a.m. Tuesday next.

The Council adjourned at 5.03 p.m.